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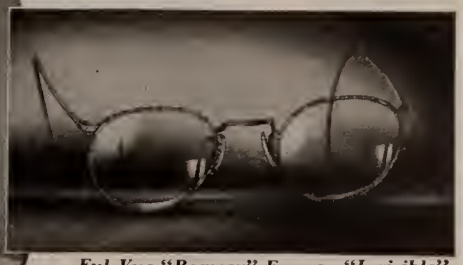
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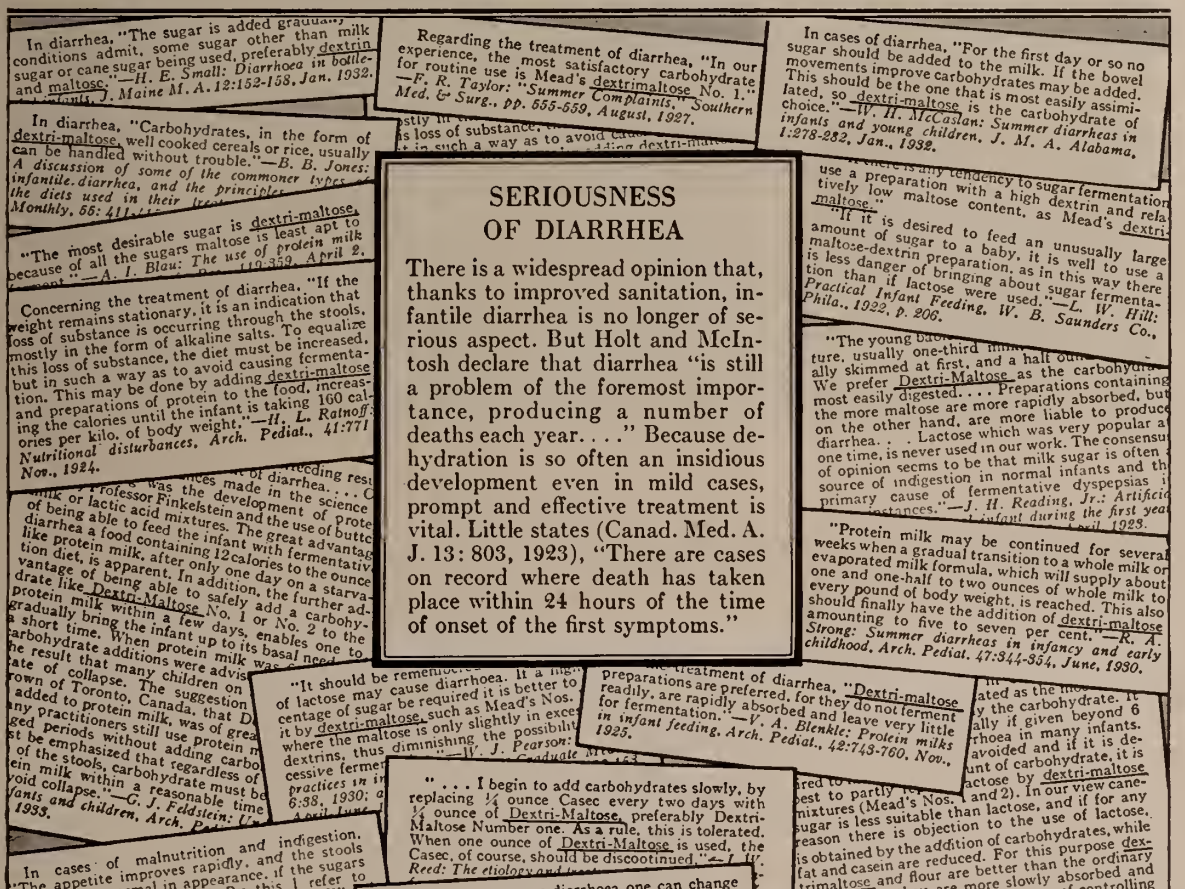
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HYPOGLYCEMIC SHOCK THERAPY IN DEMENTIA PRAECOX*

H. Mason Smith, M. D.,
Tampa.

Reports from several European clinics of the marvelous results obtained in the treatment of dementia praecox through the use of hypoglycemic shock therapy have gained much publicity in the lay press and have aroused widespread interest and enthusiasm within the medical profession. In consequence, the Committee on Public Education of the American Psychiatric Association deemed it expedient to issue a statement warning both the public and the profession regarding this new therapy. In this warning, concurred in by all members of the committee and also by Dr. C. Macfie Campbell, president of the association, it is stated that the impression that there is no effective treatment for dementia praecox is erroneous. As quoted in the Journal of the American Medical Association, February 13, 1937, this pronouncement further stated that insulin shock treatment is being studied in the state hospital systems of New York and Massachusetts, in Bellevue Hospital, New York, and in other scientific centers and is to be undertaken only by physicians adequately trained to cope with its dangers.

When the statistics of the European clinics show that three-fourths of the patients who have been ill less than half a year are completely recovered under this therapy and that over 69 per cent of those who have been ill less than a year and a half are benefited to such an extent that they are able to return to their work, becoming productive, socialized individuals, it is but a perfectly natural sequence that this method of treatment be given the publicity and extensive trial it should receive. In cases of dementia praecox the spontaneous recoveries number less than 10 per cent, and the remaining large group consists of chronic and incurable patients with a very long expectancy as custodial insane persons, most of whom become charges of the state. In view of these facts every parent whose child has recently developed dementia praecox is entitled to know the use now being made of this new therapy and the promise it holds out for recovery. To wait until the conservative gentlemen from the East have satisfied themselves on every point is analagous to postponing a call to the fire department while the house burns down, in order that some eastern engineers may pass on equipment that has been used satisfactorily elsewhere. Although the treatment is attended with grave dangers, any parent or physician who is acquainted with the progressive and chronic nature of this disease would certainly be glad to take the chance involved, for practically anyone would agree that death is decidedly more merciful to an individual than a lifetime of acquired feeblemindedness brought about by the ravages of this dementing process.

As to the statement that there are other treatments for dementia praecox, there is none that has ever proved effectual. In the treatment of this disease, as with poliomyelitis, multiple sclerosis, the primary muscular atrophies and other diseases with obscure etiology, many therapies have been proposed and tried, but so far no treatment other than that of hypoglycemic shock has proved efficacious for it.

In 1933, Manfred Sakel,[1] a young Viennese physician, observed that narcotic addicts, under treatment for diabetes, who experienced reactions from insulin, had no withdrawal symptoms while in the shock or pre-shock period and for some time following. He developed the simple hypothesis that the withdrawal symptoms were a sign of general nervous hyperactivity such as he saw in hyperthyroidism; that the nervous system was continually exposed to the activity of circulatory hormones, especially the hormone of adrenalin, and that the withdrawal symptoms were therefore due to nervous hypersensitivity or to an excess of excitant hormones. In either

*Read before the Sixty-fourth Annual Meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, 1937.

case, a reduction of adrenalin should, he felt, have a quieting effect. He used insulin as an antagonist to counteract the hyperactivity from the adrenalin. Whatever the real answer, the practice proved effectual in narcotic cures. The same hypothesis was also applicable, he thought, to psychosis; so he began to apply it to schizophrenics. The response of the first few schizophrenics was sufficiently gratifying to justify and encourage further research. With these patients, however, he carried the hypoglycemic state so far as to produce shock while in the cases of narcotic withdrawal, he did not give the patients such massive doses of insulin. In treating schizophrenics, hypoglycemic shock is the criterion, the instrument which produces the benefit.

RESULTS

In estimating the results of this treatment, practically all of the research workers have considered a complete recovery as meaning one thing only, complete and total rehabilitation of the personality including affectivity and also capacity for work. A "good recovery" means that the patient is able to leave the hospital and return to his profession or occupation, but there may be a few residuals. A "social recovery" means that the patient may not return to his profession, but is able to remain at home and work without supervision at a simpler occupation. Other than these, cases are not recorded as recoveries. The word "improvement" is in the field of psychiatry such an intangible and unmeasurable term that it is left out altogether in estimating results. When a patient does not attain a social recovery, the treatment is regarded as a failure in that case.

The first statistics available were tabulated and published by Dussik and Sakel[2] in 1936 and comprised 104 cases. Fifty-eight were recent cases and forty-six were of six months' duration or more. In the fifty-eight recent cases, 88 per cent of the patients made good recoveries, enabling them to return to work; 70.7 per cent made complete recoveries. In 19.6 per cent of the forty-six older cases complete recovery was attained, and social recovery in 47.8 per cent of this number. These cases were discharged as cured and others taken in for treatment. The "follow-up" showed that fifteen of the patients making good recoveries had remained well a year, and thirty-four others were still well at the end of half a year. Three making complete recoveries, five making good recoveries and one making a social recovery had relapsed at the end of a year. Of these nine, five were again placed under treatment; three made good recoveries, one was benefited and one was still under treatment. In this series there were three deaths, one from coronary thrombosis and two from pneumonia following aspiration. In one of the latter cases pancreatic necrosis was found.

Addressing the Bern-Stadt Medical Society on February 13, 1936, Mueller[3] summarized the work done in Switzerland. Of the seventy-five cases reviewed, 48 per cent or thirty-six patients showed complete recoveries. Of this number, twenty-six had been ill less than half a year, nine between half a year and a year and a half, and one more than a year and a half. So in all these reports the recent cases showed more response to treatment than the older ones. In fact, of the thirty-six complete recoveries in this series, 76 per cent were recent cases. Total failure occurred in only eighteen of the entire seventy-five cases.

Since this report was made, 118 cases[4] have been tabulated in Swiss clinics. Seventy-eight of the patients in these cases were ill a year and a half or less, and 68 per cent of this number made complete recoveries. In forty the duration of the illness was more than a year and a half, and out of that number two made complete recoveries, sixteen made social recoveries and twenty-two were not benefited. Hoff[5] reported later on 200 cases treated in the Vienna Polyclinic. In this series 70.7 per cent of the patients made full and complete recoveries, revealing not the slightest residue of schizophrenia upon closest examination. In the earlier cases the proportion of recoveries was 86.2 per cent, and in the older cases 45 per cent. The mortality rate was 1.5 per cent, or three deaths in 200 cases. Sakel[6] now has record of 300 cases.

In this country there have been practically no reports of this treatment as it has not been in use sufficiently long to justify them. Steinfeld,[7] of Peoria, Illinois, observed the treatment in three old cases in which results were negligible. Glueck[4] reported the privilege of following through twenty cases while visit-

ing European clinics last year. Dr. John R. Ross, Superintendent of the Harlem Valley State Hospital, Wingdale, New York, where the treatment is in use, stated: "Improvement has occurred in a number of cases; from the twenty cases that have been receiving treatment we are now ready to send eight home for trial and possibly more at a later period."[6] No doubt in a few months many clinics will have tabulated reports.

My personal experience with the treatment has not been large for it has been limited to six unselected cases in which shocks were produced. It has, however, been sufficient to justify the claim that this therapy can be successfully carried out in a well equipped general hospital, thereby saving the necessity of committing the patient, an important factor to many people.

METHOD OF ADMINISTRATION

In the first of four phases into which Sakel[1] divided the treatment, the patient is given from 12 to 20 units of insulin, and the amount is increased 5 or 10 units each day. The initial dose is usually given in the morning at six or seven o'clock on an empty stomach, and the patient is kept in bed without food, although water is allowed throughout the treatment as the patient desires it. After four or five hours have elapsed, 150 grams of sugar are given in some liquid, such as milk, tea or coffee. If this first dose of insulin brings about excitement, another dose is given at two o'clock. This treatment is continued six days a week with one day allowed for rest. During this phase of the treatment, hypoglycemic symptoms begin to appear with increasing severity as the dose of insulin gets larger. These symptoms are profuse sweating, increased flow of saliva which is viscid, and tremors and twitching of the muscles in the face and lower extremities. As far as I can learn the patient has a subjective sensation of well-being. Occasionally there occur oppressed feelings around the heart with pounding and also a state of anxiety. This phase ends when the dose of insulin has become sufficient to produce hypoglycemic shock.

When the dose is sufficient to produce the pre-shock stage, there is usually an activation of the psychosis. In some patients it occurs in reverse form. A catatonic who has been mute for years may under shock doses of insulin become somewhat talkative and excited for an hour or two before going into shock.

The second phase of the treatment is arbitrarily determined when the patient goes into shock. It is the most important phase and is reached when the dose of insulin produces a degree of coma in which the patient is no longer able to drink soluble solutions and nasal feeding or glucose administered intravenously has to be resorted to, or when the patient is threatened with a convulsion. When profuse perspiration occurs during the coma, the shock is designated as a "wet shock." The patient who does not perspire is more likely to have a convulsion at the onset of or during the hypoglycemic coma. A convulsion indicates that the shock should be terminated by neutralizing the insulin.

During this phase of the treatment the attendants should be ready for all emergencies, and a physician should be in constant attendance. Adrenalin should be conveniently at hand, already in a syringe; a Levine feeding should be prepared and ready for administration; glucose for intravenous injection should be readily available; also, within easy reach there should be cardiac and respiratory stimulants such as coramine and caffeine. When the patient reaches a state of shock, the somnolence passes into a coma of variable depth, and he cannot be aroused by shaking. The normal reflexes are abolished, and pathological reflexes are found present. In deep shock there is a total abolition of reflex activity. The patient becomes pale; often marked bradycardia is present and there occur tremendous fluctuations in blood pressure, which may range from 180 to 90 in five minutes; also marked twitching and clonic movements occur.

It has been difficult to determine the length of time the coma should be maintained. It is probably desirable to continue it as long as the patient's physical state indicates to the physician that everything is moving well. At present, however, the consensus is that it should be maintained from four to six hours and interrupted at any time if there is cardiac or respiratory embarrassment.

The number of shocks to be given is determined by the progress of the patient. When there is no activation of the psychotic symptoms during the pre-shock period and

when there is a normal behavior with a disappearance of all the schizophrenic characteristics, this phase of the treatment is terminated.

The third phase consists of a rest period given one or two days each week and sometimes longer. In old cases after thirty or forty shocks have been given, a period of rest for sixty days is sometimes allowed. One of my patients, who has had thirty-five shocks, is now resting for sixty days and will then return to the hospital so that I may repeat the treatment.

The fourth phase is termed by Sakel[1 2] the "polarization phase." It consists in giving insulin once or twice a day in less than shock doses and neutralizing these doses two hours later. It is really a tapering-off process. This phase usually requires a week or ten days, and during this time the patient becomes oriented and adjusted to the withdrawal of insulin.

The variability of the reaction of the individual patient and of different patients to insulin is amazing. This difference of sensitivity probably depends on the insulin antagonist, adrenalin, and also on pituitrin, which in turn affects the progress of the hypoglycemic state. According to Sakel, [1 2] old cases of schizophrenia seem to be more resistant to the effect of insulin than recent ones. He has carried this idea to the point of claiming that he can tell the duration of the schizophrenic disorder from the patient's responsiveness to insulin. In one case in my series, the patient walked around the hospital after receiving a dose of 310 units. In other cases we obtained a shock following the administration of 25 units. The latter were, of course, recent cases, and the illness of the catatonic who tolerated the large amount was of ten or twelve years' duration.

It has already been brought out that this treatment involves dangers considerable in degree. In my personal practice there have been many difficulties. In the first case, which was treated before the literature had been studied, we at one time produced such a deep coma that the administration of glucose intravenously did not bring the patient back to consciousness. In most cases the accumulation of a thick viscid mucoid saliva offers a problem, and ever present is the danger of pneumonia following aspiration, which one of my patients experienced. The patients are sometimes set up in bed so that the flow into the stomach will be easier. The suction machine is used, and atropine is freely administered. Adrenalin reduces the shock and is not used unless a convulsion or a circulatory disturbance is threatened. Bronchoscopic suction has not been used, but arrangements have been made for its use with the next patient who aspirates.

There is no value in determining the blood sugar content in the hypoglycemic state as it is of no use in determining the amount of insulin to be administered. The deepest stage of the coma does not correspond to the lowest blood sugar content. It is considered that the hypoglycemic symptoms are not due to hypoglycemia as such, but to the individual reaction to insulin, that is, to the compensatory secretion of adrenalin. Whether this reaction is considered as primarily toxic or secondarily conditioned by the hypoglycemia is problematical.

Tremor, pounding of the heart and a sense of oppression are symptoms considered due to adrenalin, whereas weakness and sweating are regarded as the direct result of hypoglycemia. The convulsions are manifestations also probably due to adrenalin. One of the most serious difficulties is the epileptic convulsion. There are, however, other complications, such as circulatory collapse, glottal spasm and vomiting during the stage of unconsciousness, but with these I have fortunately not had to contend. There is also the possibility of after shock, which no doubt occurred in the first case of my series, in which the patient remained in a coma for more than forty hours. One has to deal here with a spontaneously developing hypoglycemia, which sets in a few hours after the induced hypoglycemic state has been neutralized.

In view of the fact that internists have had disastrous experiences with spontaneous hypoglycemia in the treatment of diabetes and that cardiac failure has been the cause of death in insulin shock, the heart deserves special attention in the production artificially of the hypoglycemic state. In practically all hypoglycemic states tachycardia is observed. It may persist afterward for a number of hours, but it disappears within twenty-four hours. Occasionally bradycardia is present, the pulse becoming very slow. The three essentials to

perfect cardiac function are: sugar, insulin and oxygen. If the sugar content of the blood is reduced too much, there is danger of lasting injury to the heart. Emphasis must be placed on the point that the circulatory system is to be guarded most carefully during insulin therapy, and patients suffering from heart disease or coronary disease should not have the treatment. Persons in the arteriosclerotic period of life are in great danger when subjected to this therapy. Fever is a contraindication.

THEORY OF INSULIN SHOCK

There has been no satisfactory explanation of the biochemical reaction in insulin shock that brings about the improvement in the psychosis. It is hoped that when this reaction is known, the etiology of dementia praecox will become known. Wortis[1] presented Sakel's views and tentative working theory as follows: "(1) Insulin shock stimulates metabolism in general and liver function in particular, so that toxins are eliminated; (2) insulin shock, like any other shock, revives strong, primitive, normal responses and eliminates recent abnormal ones; (3) insulin has a specific vagotropic action. Sakel pictures schizophrenia as a state in which nerve impulses travel fast and free and fly, so to speak, off the handle. Insulin inhibits and blockades the nerve cell, so that the nerve pathway patterns, like jurymen locked in a room, finally come to order. The seat of action, he believes, is the vegetative centers."

My personal view is that the brain is dependent on carbohydrates for nutrition and that in schizophrenia the carbohydrate metabolism is low. Insulin drives the sugar from the blood stream into the deep organs and improves the carbohydrate metabolism of the brain. By animal experimentation Yamada[8] has shown that insulin diminishes production of lactic acid in the brain by promoting conversion of lactic acid into glycogen, a finding which indicates that the potentialities of research in this field are great.

In the later stages of treatment the patients are susceptible to psychic influences, and the psychic effects of coma and shock may indeed be factors of considerable import in the treatment. Psychotherapy in these stages is certainly of benefit.

FUTURE OF THE THERAPY

If the clinics of this country in administering this treatment meet with the success the European clinics have had with it and obtain as high a percentage of recoveries that remain permanent or even measurably so, the discovery of this therapy will constitute, because of its far-reaching medical and social implications, one of the greatest advancements of medicine. Physicians who have worked in psychopathic institutions will agree that there is nothing more tragic than to see the hopes of parents blighted by the development of schizophrenia in a child who has shown evidence of brilliance and even genius.

The present population of state hospitals is composed largely of schizophrenics who went to these institutions as young people and have continued to remain there, buried in custodial care and having a rather lengthy expectancy of life. Their care has, of course, been a tremendous expense to the respective states. According to reports of the federal census, during 1934 there were 150,000 patients suffering from dementia praecox in state hospitals alone without reference to private institutions. The federal census for 1935 showed a total of 19,149 new cases of dementia praecox committed that year. Successful treatment of this disease will effect tremendous economic savings and will solve to some extent the problem of overcrowding that has bothered all state hospitals.

It is reasonable to assume that producing the hypoglycemic state is not necessarily specific for schizophrenia, and already it has been used successfully by me in some cases of neurosis that have been under my care for years. Its use with success has been reported in a few cases of menopausal depression and a few cases of compulsion states.

With experience in handling patients under this treatment in a well equipped hospital, it is possible to modify its dangers. The treatment should, of course, not be undertaken without due caution and proper facilities. It can be carried out successfully in any general hospital that contains a good psychopathic ward with a trained personnel of physicians and nurses, and the necessity of committing many patients to state institutions may thus be relieved.

Regarding possible injurious physical se-

quelae owing to repetition of the insulin shocks nothing definite has as yet been published. Certainly while undergoing treatment the patients appear to be in excellent physical condition and usually gain weight. Beyond a sense of fatigue, they have practically no discomfort during the time they are not in a hypoglycemic state. Apart from certain guiding principles, the therapy is individual in character, and the director of the treatment will have to be guided by intuition and good judgment in determining the depth of the shock and the number of shocks to be administered.

CASE REPORTS

Case 1.—A truck driver, white, aged 20 years, was admitted to the Tampa Municipal Hospital December 16, 1936. Except for the removal of tonsils and adenoids, his medical history was negative. Always somewhat seclusive in disposition, he was brilliant in his studies. He was at the time of admission in a somewhat disturbed mental state. He stated that while driving his truck, he would be unable to remove his eyes from a house or other object on which his gaze chanced to fall, and that his mind would not tell him he was physically fatigued, leaving him to find out two or three days later when his body felt very weak. He was deeply concerned, he said, about the Bible, which until six months previously he had been unable to understand but now comprehended fully in all its various injunctions and commands. Believing he had been gassed in order to be put to sleep the first night in the hospital, he held his neck because he thought the gas had injured it. He also thought he was being treated by electricity and that waves were passing through his body. He felt that he was all right, but that things without were disordered and that certain people could in a way tell all that was going through his mind. He was grimacing and displaying peculiar mannerisms, and emotional poverty was evidenced by his inability to enjoy anything pleasant. He was indifferent to his environment, showing no concern about being in the hospital or going to the state hospital. Except for vagotonia, physical examination was negative.

Exceedingly anxious to avoid commitment for this young man, his family was highly desirous of keeping him in the Tampa Municipal Hospital as long as they were financially able to do so. On being informed of a new therapy, they were so insistent that it be tried that we finally agreed to administer insulin shocks although we had not yet had the benefit of reading the literature pertaining to the method of administering this treatment.

On the first morning the patient was given 20 units of insulin on an empty stomach, on the second morning 35 and on the third morning 55 units without reaction. In order to produce a shock without using more of the drug than necessary, it was decided to give the insulin every two hours until he lapsed into coma. At eleven o'clock on the night of December 24, after receiving 172½ units at intervals of two hours, he went into a coma, and two hours later had an epileptic seizure of eight minutes' duration. Following the convulsion his circulation was, however, so good that the shock was not interrupted, and he was allowed to remain in the coma for four hours.

The next morning the patient was perfectly normal in all respects. The schizophrenic symptoms had disappeared, and he had sufficient insight to analyze and discuss them. As he remained normal and so little was known about the treatment, he was sent home on December 27. Eight days later the symptoms returned, becoming as pronounced as at first, and the patient was readmitted to the hospital on January 7.

Still unable to procure the literature on the new treatment, we produced shocks by giving the patient 60 units of insulin at six o'clock in the morning and 40 units two hours later. In this way four "wet shocks" were obtained and interrupted without difficulty, the patient showing daily improvement. Following the fifth shock, there was difficulty in bringing him out of the coma. Fifty cc. of 50 per cent glucose were administered three times at intervals of two hours. Adrenalin was given, and at one time coramine and caffeine when the circulation became poor, but the patient remained in the coma. At eight o'clock that night he had a clonic spasm of forty min-

utes' duration. Adrenalin was given at that time and the third dose of glucose. As the circulation was now good, he was left alone and only watched. After forty hours he came out of the coma, and again in a perfectly normal state.

On the day following this fifth shock, Sakel's original article in German arrived, and translation revealed how great had been the deviation from his technic in the management of this case. The patient was, however, apparently well, but he was kept in the hospital a week longer and subjected to the polarization or tapering-off phase of Sakel's treatment. He was discharged as well on January 24 and has been in my office several times since. There have been no residuals of a schizophrenic breakdown. He is completely rehabilitated, has gained weight and returned to work.

Case 2. — An attorney, white, aged 30 years was admitted to the Tampa Municipal Hospital January 16, 1937. There was a history of restlessness and nervousness since an attack of influenza, which the patient had eight years before in a military camp at Columbia, S. C. In August, 1933, while in court defending a client for murder, he experienced his first hallucination in the form of a radio voice talking to him. Shortly afterward a client came into his office one day intoxicated and armed with a gun. He felt the man was pursuing him for the purpose of murder and spent many days and nights in a state of anxious excitement fearing for his life. He was taken to the beach, and many other things were done to allay his anxieties, but he finally collapsed.

Placed in a sanitarium, he became so suspicious and afraid of everybody that he could not very well be treated. He remained two months at the state hospital that summer and after six months at home was readmitted there, remaining ten months. After he returned home the second time, the radio voice talked to him continually and he spent most of his time sitting around talking in an undertone in reply. He became restless, impulsive, threatening and pugnacious. Several times in a state of anger he almost committed homicide. He threatened his mother with knives and at one time threw a piano stool at her.

When he became so much worse that he was about to be committed again to the state hospital, a plea was made that he be treated in the Tampa Municipal Hospital. On admission he was restless, constantly moving about, and he could not sleep. He was irritable, touchy, pugnacious and at times noisy.

Treatment was started with an initial dose of 20 units of insulin given the patient on an empty stomach at six o'clock in the morning. The dose was increased 5 units each day until he went into a "wet shock" on the administration of 70 units. His shocks were interrupted with Levine feedings until a nasal obstruction prevented and glucose was then given intravenously. Thirty-five shocks were administered.

Improvement in the condition of the patient was obvious from the beginning. Throughout the period of treatment his appetite was good; his skin cleared up; he gained weight and began to sleep well. His psychomotor restlessness was completely relieved and he was cordial to the nurses, becoming quite social in his demeanor. The radio voice, which continued to come, was neither so loud nor so constant and did not bother him much, he said, for there would be hours when he did not hear it at all. During the intervals between hypoglycemic states he read and enjoyed a history of France.

During the last shock administered, he aspirated much mucus into the lungs and developed a pneumonia in the left lung. He coughed up the aspirated material without difficulty, however, and made a good recovery. On March 14 he was discharged.

This patient has made a "social recovery." While he cannot take charge of his practice, he is able to do some legal work in his office. His antisocial activities have been blocked and he is thoroughly amenable to life at home. Although already a "social recovery" can be recorded in this case of four years' duration, the patient is expected to return to the hospital for further treatment after a period of sixty days has elapsed.

Case 3.—A white man, aged 35 years, was admitted to the Tampa Municipal Hospital, January 18, 1937. Son of a prominent physician in New England, he came of a family of distinguished professional men and had a brother who was a surgeon in New York. Except for an attack of scarlet fever from which he made a good recovery at the age of four years, his medical history was not important. He was a strong, healthy boy, larger than the average but well formed. An average scholar, he was especially good in mathematics. He enjoyed his friends and participated in sports.

At the age of sixteen years he appeared not to be well. On physical examination, made in Boston, urinalysis showed casts, much albumin and a few red blood cells; a diagnosis of subacute nephritis was made. The kidney condition remained about the same until the patient was twenty-two years of age when mental symptoms developed and the urine cleared up entirely. At a state hospital in New England, where he spent two weeks thirteen years ago, the case was diagnosed as dementia praecox of the catatonic type. His father took him to many clinics, but the diagnosis was always the same and little promise was held out for recovery. Following an abdominal operation in July, 1926, his weight increased from 125 to 200 pounds, he improved in general health and showed some improvement in his mental condition. He was subjected to occupational therapy and appeared to be interested in some of the things going on around him. Apparently he listened to the reading of a newspaper. He was, however, negativistic, catatonic and completely mute during all these years.

When admitted to the hospital, he was physically in perfect health, a rather large, stout individual with advanced catatonic symptoms. His position in standing was purely statuesque as he never batted an eyelid. He did, however, have some impulsive and spontaneous movements. In all public places he would shake his head almost constantly, at first slowly and then rapidly, very much as a bull does before charging.

Beginning with an initial dose of 25 units, insulin was given the patient on an empty stomach each morning, the amount being increased 5 units daily until it was obvious that there was very little reaction. The dosage was then increased 10 units each day, and at the end of two months he was receiving 310 units without going into shock. It was at least amazing to see a man walking around the hospital, apparently comfortable, after an injection of 310 units of insulin. Fortunately, 315 units, given the next day, produced a shock.

In the pre-shock stages, this patient has been talking, calling for his father, asking about his mother and at times singing in a rather incoherent way, but each time at the termination of the shock mutism returns and no word can be brought from him. He shows negativism in no other way. The rigidity and statuesque appearance have been somewhat ameliorated, and there is less cataleptic appearance when he is walking around. Before a complete shock was produced, the psychomotor restlessness manifested by the shaking of the head had discontinued, and there has been no return of this feature. The patient is perfectly amenable to home life, and the only obvious psychiatric symptoms are his mutism and rigid appearance. This case cannot, of course, be classified as a recovery, but the patient is still under treatment and has shown marked benefit. Twenty shocks have been given.

Case 4.—A white woman, aged 23 years, was admitted to the Tampa Municipal Hospital January 26, 1937. Her history showed that as an infant for a long period she had colitis and then infantile paralysis, as a result of which one leg was shorter than the other. She did not talk and walk until she was two and one-half years of age. Remaining somewhat childish, she did not develop emotionally into a well regulated adult. Because of unhappiness and failure in mathematics she was unable to enter the senior year of high school. From childhood she had been difficult to manage, was always obstinate about going to school, cared nothing for playmates or clothes but did enjoy swimming, bicycling and other sports.

Two years prior to admission to the hospital she began running away from home, became very elusive and would escape at night when not under guard. At that time she began having hysterical tantrums and sometimes without provocation would remain secluded in a room all day. She was irritable and attached all difficulties to her mother. As she grew more infantile in her demeanor, her case was regarded as a simple case of regression due to the environment of a somewhat pampered undeveloped child. Eventually she became not only more irritable but also negativistic and pugnacious. Several times she attacked her mother and a few times threw missiles which, if well aimed, might have inflicted fatal injury. In view of the fact that there was no place to send this young woman except the state hospital, her parents plead that she be given the hypoglycemic shock therapy.

The first phase of the treatment was entered into very cautiously. The initial dose of 15 units of insulin was gradually increased to 50 units, the amount necessary to produce a shock. In all, four shocks were administered, and during the last one the patient suffered a convulsion. From the very beginning there was improvement in her condition, and she was discharged from the hospital on February 28. Since that time she has been able to remain at home, has been less antagonistic and less infantile in her demeanor, and has become more amenable to directions. She has shown more pride in her appearance than ever before in her life and has become ambitious and energetic about helping with the housekeeping. This case is regarded as a good "social recovery."

Case 5.—A white girl, aged 18 years, was admitted to the Tampa Municipal Hospital February 13, 1937. She was a well developed young woman who had broken down nervously while attending college in Virginia the previous fall. At that time she complained of weakness and exhaustion, but showed no psychiatric symptoms, except a slight emotional disturbance. She was hysterical, would cry easily and at times became very depressed. She recovered from this condition and came to Florida in January. A few days after her arrival she began screaming and yelling, but would express no reason for all the disturbance. She became absolutely uncommunicative and responded to all questions by yelling the louder. She reacted so poorly to drugs that it required large doses to make her sleep. After several days she became quieter but lost interest in everything, even her relationship with the relatives she was visiting. She remained uncommunicative, refusing to talk to anyone, and even refused food, but went around the house whining all day.

After admission to the hospital, her appetite increased during the preparatory phase of the treatment. Fifteen units of insulin were given at first, and the amount was gradually increased to 50 units. When the dose was large enough to cause some reaction, she showed a tendency to go into a convulsion rather than into a coma. Convulsions followed the first three shock doses. Adrenalin finally stopped this tendency, and she had a "wet shock," after which she was perfectly normal for a period of thirty minutes. She has had twelve "wet shocks" and now the mental condition is normal for two hours after each shock. Also, during the intervals between the hypoglycemic states she shows a much better reaction. She responds to questions, assists the nurses in waiting on the other patients, and sometimes gets them water and does other things for them without a request from the nurses. This patient is still under treatment, but the favorable results already obtained suggest a probable complete recovery.

Case 6.—A cigar maker, white, aged 45 years, was admitted to the Tampa Municipal Hospital, March 13, 1937. He was in perfect health physically, but had for a year been having paranoid delusions. The condition advanced to the point where he was having hallucinations almost constantly. He heard voices talking about him wherever he went, and while working in the cigar factory, he would hear his wife tell him she was "stepping out" with young men every night. He believed and acted on this information in spite of the

fact that he was with his wife almost constantly when not at work. While working on the cigar bench, he was continually looking around, fearing that someone was slipping up on him, and when the closing hour came, he refused to leave the factory because he was afraid a group of people outside would attack him.

He was apprehended and brought to the hospital. Twenty units of insulin were administered at first, and the amount was increased to 90 units, but the treatment was interrupted before the shock occurred. At the end of two weeks all the hallucinations had disappeared. As far as his relatives could discern, he had no paranoid trend of thought. He was discharged last week, and for the few days that he has been out of the hospital, his behavior has been perfectly normal. He has shown no paranoid tendency.

SUMMARY

Reports from European clinics of the successful use of hypoglycemic shock therapy in the treatment of dementia praecox merit for the treatment due publicity and extensive trial in this country. There are four phases in the administration of this therapy, and because of the dangers which attend it, the treatment should be given only under the direction of adequately trained physicians with suitable facilities at hand for the proper care of the patients. The series of six cases here presented has demonstrated the feasibility of carrying out this treatment in any well equipped general hospital with a good psychopathic ward, thereby avoiding the necessity of committing these patients to institutions. Results in these six cases have been gratifying. As none other has, this plan of treatment offers hope of reclamation from an otherwise almost hopeless condition to individuals afflicted with dementia praecox and at the same time gives promise of tremendous economic saving to state institutions throughout the country now overcrowded with patients, a large proportion of whom are schizophrenics. It is here suggested that insulin shock improves the carbohydrate metabolism of the central nervous system and that it may be useful in conditions other than schizophrenia.

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A SUMMARY OF THE PRESENT STATUS OF FEVER THERAPY PRODUCED BY PHYSICAL MEANS.

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The First International Fever Congress was held in New York City the last week in March, 1937. Within three weeks practically every leading magazine in the country broke with articles written for the laymen.

Coincidental to these events is the fact that we have aided in the pioneering of fever therapy in the South since 1928. The end result is that for the past six weeks our department has become completely flooded with inquiries by telephone, telegraph, personal communications and mail from both the profession and public at large. The problem of supplying this information has become so acute and difficult that we are asking the publication committee to publish this brief manuscript as soon as possible in order that the profession may be better grounded in the fundamentals of this subject and thus be competent to help take care of this sudden demand.

No attempt is being made to discuss in detail or at length any phase because manuscripts already compiled by various investigators are in process of publication and will appear in scientific periodicals during the ensuing months.

DISEASES TREATED AND THOSE NOW UNDER STUDY

Syphilis, gonorrheal infection and bronchial asthma have received the greatest amount of study both as to volume of cases and seasoning in observation time. There is no longer any debate as to the value of pyretotherapy in syphilis. Essentially all of the pioneer investigators in this field have reached the agreement that the combined fever and chemotherapy is far superior to either being used individually. The arsenicals are administered at the peak of the temperature and the other heavy metals are given between the pyretic treatments. When contacted during the primary stage the spirochetes in the chancre are broken into fragments and rendered immotile during the first treatment. Spirochetes inhabiting the first chain of lymph nodes adjacent to the chancre are changed in morphology but some remain feebly motile and will recover and propagate if treatment is stopped at this point. Following the second and third fever sessions they are fragmented and rendered immobile in the lymph chains. Six treatments, however, are considered the minimum course of safe treatment in the primary stage. The temperatures must reach 105.8° F. or above and the maintenance period from seven to nine hours. I consider ten treatments a minimum course for secondary lues and twenty treatments for tertiary or central nervous system involvement. The results of fever therapy in these cases are soundly and definitely established and they are spectacular.

Gonorrheal infection runs a close second, if not first rank, to lues in experimental study. There is no more pleasing sight in medicine to me than to see this infection with its complications melt away under properly governed fever. Six to ten treatments are required by the ordinary fever set-up but by utilizing a combined technique of generalized hyperpyrexia with local pelvic heating in the female the infection is being conquered in one and two treatments. Our experience in this infection has taught us to elevate the temperature to 106.8° F. and maintain at least five hours. Some investigators, however, are reporting good results at lower temperatures.

Bronchial asthma has been subjected to a fair and impartial trial. The verdict is that as a specific hyperpyrexia by physical means is of much value in breaking the acute attack. Beyond this it is of considerable value as an adjunct in combination with other measures of treatment.

Chorea and acute rheumatic fever in children have been treated and were reported at the conference with gratifying success.

Nonspecific arthritis has received much study and the results have been variable. Undoubtedly, it is worthwhile to try hyperpyrexia in these cases but do not give too much assurance of end results.

Multiple sclerosis has received considerable study with hopeful outlook although sufficient observation and seasoning has not elapsed to settle the question of remission and relapse.

Cardiovascular syndromes including essential hypertension, peripheral vascular lesions and angina have been studied and the reports are favorable. Malignant endocarditis failed to respond in the few cases reported.

Ocular disease embracing gonorrheal ophthalmia, luetic interstitial keratitis, corneal ulcer and luetic iridocyclitis were all reported with very favorable results. The neonatorum infection responds in from two to three treatments.

A miscellaneous group including pulmonary tuberculosis, undulant fever, nonspecific neuritis and various otolaryngological conditions have been reported with promising outlook but as yet need further development.

DANGERS, SAFETY AND CAUTION

There can no longer be any logical dispute as to the relative safety of artificial fever produced by physical means over that produced by foreign protein, malaria or other induced infections. Any argument henceforth can be initiated only by those not experienced in both methods. Nevertheless, it must be definitely emphasized that all methods of inducing artificial fever carry with them grave potential dangers and should never be attempted except in a specially equipped department in a hospital and under the guidance of skilled technicians who have been trained in fever therapy. For this sole reason we have for the past three years kept three technicians under training constantly in order to supply the demand for fever technicians as they have arisen in the various parts of our territory.

Prolonged fever therapy is a strain on any patient and, therefore, complete physical and diagnostic studies must be routine before exposing him or her to treatment. The skin, genito-urinary and cardiovascular systems must especially be surveyed in advance. The next safety measure comes in the proper selection of apparatus.

MACHINES AND EQUIPMENT

Personal experience has taught me that I would rather trust a skilled and trained physician with a bath tub than one lacking in fever training with the best apparatus made. We began attempts at inducing fever in 1928 and 1929. From that period until the present we have given over 7,566 treatments and over 22,500 hours of fever. In this experience we have both enjoyed and suffered experiences with the following methods of producing fever by physical means: incandescent light cabinets, hot baths, electric blankets, various hyperpyrexators, vapotherms, infra-red dry hot packs, high frequency current diathermy, radiothermy and electromagnetic induction. The scope of this brief summary does not permit detailed comparative discussion of these modalities and furthermore a manuscript, now in process of publication, covers the subject in full with detailed graphs and tables. Suffice it to say that this experience has led us to our present set-up of choice which consists of three, namely high frequency diathermy, electromagnetic induction with fever bag insulation and electromagnetic induction combined with the air conditioned cabinet. Should we be limited to one piece of apparatus the last named would be our choice.

MAJOR PHYSIOLOGICAL CHANGES

The most constant of these is an increase in the leukocytes ranging from 5,000 to 23,000 cells during the treatment. There are slight changes in the red cell count and the differential by Schilling count shows a shift to the left. Bone marrow punctures reveal a stimulation of the hematogenic function. There are mild and variable changes in nonprotein nitrogen, creatinine, sugar of the blood, acid base equilibrium, changes in blood volume, loss of chlorides and some changes in blood cholesterol.

SUMMARY AND CONCLUSIONS

Fever therapy by physical means is definitely established and is here to stay. Information has been so rapidly and widely disseminated to the public that the demand will compel physicians to familiarize themselves with its fundamentals and to do it rapidly. The fundamental essentials are: choose the proper disease, employ only skilled and trained technicians, conduct a thorough diagnostic survey on every patient to be subjected and choose the proper and most physiological apparatus available.

RADIO BROADCASTS—WRUF

The Committee on Public Relations of the Florida Medical Association has been very active during another year. For the convenience of those who desire to refer to the text of broadcasts, the Public Relations Committee has requested the editor to publish the broadcasts in one number of the Journal. The July number has been designated for this purpose and the chairman of the Public Relations Committee has assembled the broadcasts for publication in this issue. He has also prepared an editorial on this subject which appears in this Journal.

THE BATTLE OF THE CHILDREN*

R. H. Williams, M.D.,
Eustis.

For thousands of years mankind's greatest battle for existence probably was waged by the infants and children. Thousands of years ago children probably were no healthier, no stronger, no more robust than the boys and girls of today. We have every reason to believe that there existed among those early peoples the same causes of disease that produce the illness of children in modern times.

There were the unseen enemies, which we now know as germs, and there were other foes of child life which modern children, fortunately, are not compelled to meet. The early savages and barbarians, when food supplies were limited, did not hesitate to sacrifice the lives of little children to reduce the number of mouths to be fed. Later in history, when the value of each individual was measured by his fighting power, the weak, the diseased, and the deformed, and in some instances, the female children, were exposed to death to leave the tribe free for fighting.

With the Spartans a change from a destructive to a constructive practice was seen.

*Broadcast delivered under auspices of Florida Medical Association, over Station WRUF, Gainesville, Sept. 13, 1936.

Here the particularly healthy and robust babies were selected and passed upon by a committee. They were not only allowed to live, but were most carefully reared so that their natural physical resources were added to by training. The Spartans, physically, were the finest race of their time. At that time little was known about disease prevention although from the beginning of time the human race has sought, consciously or unconsciously, to be healthy.

Disease prevention is of importance not only to the medical profession, but to all who are interested in the material and moral welfare of humanity. Other things being equal, a healthy community is a prosperous one. A pestilence-ridden region prevents all physical and mental development. This was recognized by the ancients who attempted to establish laws of hygiene and health in an effort to conserve human life and activity. However, it is only during comparatively modern times that continued progress has been made in the prevention of infectious and contagious diseases, and in the suppression of epidemics.

The advent of bacteriology, initiated by Pasteur in the last century and its development by a host of scientific workers, made the knowledge and the control of infectious diseases possible because of a better understanding of their cause and distribution. The history of the science of bacteriology presents a story whose romanticism is not exceeded in modern civilization. First of all the germs, those minute living organisms that required magnification by microscope to be detected, were discovered. They were classified into groups. Some were identified as disease producers with a deadliness that characterized them as man's greatest enemies. These tiny organisms showed variations in growth and in preferences for the food upon which they thrive. It was learned that some required oxygen and that others grew without it. It was next learned that these organisms were distributed among human beings. It was learned that they could enter the body through various portals, and that they were introduced by food, notably milk and water; that they lodged on mucous membranes of mouth, nose or throat, and multiplied by various forms of propagation so that colonies represented myriads of these bacteria in action.

Further studies showed that these minute strangers in the body showed preferences for certain tissues or organs which they invaded. Some preferred the lung for their habitat, like the pneumococcus, which produces pneumonia; others the intestine, like the typhoid group which produces typhoid fever. The meningococcus invades the central nervous system and produces a certain epidemic type of meningitis. The diphtheria bacillus invades particularly the mucous membrane of the throat and nose. It is particularly important to learn that this tiny invader and deadly enemy of childhood produces a poisonous product which is termed diphtheria toxin. This toxin has an affinity for certain structures in the body. It combines with nerve cells, or fibre cells, and produces paralysis; it combines with heart muscle causing a striking disease of this muscular organ. It is destructive to kidney cells. This led to a study of this toxin and its effect upon animal tissues. A chain of circumstances led scientists to believe that if bacteria could make toxins, the cells and defensive forces of the body could make antitoxins, because not every individual became ill when these bacteria invaded the blood and a certain proportion of human beings recovered from these bacterial diseases even before bacteria and toxins had been discovered.

The silent workers in the laboratory were continuing their labors and in an incredibly short time, antitoxins and serums were discovered which acted by neutralizing the death-dealing efforts of the virulent organisms. It was now possible to cure diphtheria, tetanus, epidemic meningitis, and recently scarlet fever has been added to the list.

It has already been noted that foods, notably milk and water, carry the agents of disease and huge epidemics may be produced in this manner. The purification of water supplies diminished the incidence of cholera and typhoid fever by destroying or preventing the pollution of the water supplies. The control of milk production may diminish the milk-borne diseases to a minimum. Unclean milk may cause the spread of tuberculosis, typhoid fever, scarlet fever, dysentery, and the diarrheal diseases of infants.

Organisms may also be inhaled into the body; the infection may be air-borne. They are probably carried by dust and inhaled.

Habitations of any kind where consumptive patients are harbored may become a menace to the health of subsequent inhabitants as persons with lung diseases may throw out droplets of spray from the mouth during talking or coughing. These droplets may contain germs which remain suspended in the air, especially in the absence of sunlight. Such air-borne infections do not readily occur in the open air where sunlight is abundant.

A great number of diseases may have their origin as droplet infections and may be considered air-borne. Among these may be mentioned whooping cough, mumps, measles, influenza, cerebrospinal meningitis, pneumonic plague, diphtheria, pneumonia and other diseases. These infections are more likely to occur in closed rooms such as over-crowded schools, factories, railway trains, tenements, and theaters.

New light was shed upon the manner of the spread of communicable diseases when the role of insect carriers was discovered. Insects which suck the blood of man transmit viruses of certain diseases. The flea which has his dwelling place on the skin of the rat may convey a dread disease plague from rat to man. The louse spreads the deadly typhus fever. One type of mosquitoes spreads malaria and another type spreads yellow fever. It is evident that the conquest of insect-borne diseases depends upon the destruction of the insects. This has been practically effected.

A heroic group of American Doctors have made Havana and Cuba habitable by destroying the carriers of yellow fever, and have made the Panama Canal Zone fit for human dwelling by clearing it of malaria as well as yellow fever. In Havana, yellow fever had not failed to make its appearance during 140 years. Under the efficient management of the chief officer, Surgeon Major William Gorgas, U. S. Army, the sanitary regulations in Havana were so modified as to require that every patient having yellow fever should not only be quarantined, but that his room should also be properly protected with wire screens so as to prevent the possibility of mosquitoes becoming infected by sucking the blood of the patient. In addition a systematic destruction of all mosquitoes in other rooms of the patient's house, as well as in adjoining houses, was at once begun. Gorgas sought to destroy all mosquitoes, infected and uninfected, within a given radius of each case. As a result, Havana was free from yellow fever within ninety days, and it has remained free.

Human beings themselves are frequently the carriers of disease. It is probable that many of the acute infectious diseases of childhood are directly conveyed from one child to another. Some persons who have fully recovered from a disease may be carriers. Typhoid fever may be carried in this manner for many years.

It has been said that public health is public wealth. If the extent of human diseases can be limited, if human life can be prolonged, the world will be wealthier in that a great burden of sorrow will be removed. Perhaps a few of us appreciate the great debt of gratitude which is due those workers who have sacrificed everything, in some instances life itself, to promote a science which has for its object the relief of human suffering, the prolongation of life and the prevention of death. Perhaps more important than the cure of the disease is its prevention. This is best illustrated in the case of smallpox. There was a time when nearly every human being contracted smallpox and many of them died. This was all changed by the discovery of vaccination by Jenner, in 1798. Smallpox is a preventable disease and its occurrence is a disgrace and a reflection on the intelligence and the sanitary status of a community.

In connection with the discovery of the toxin of diphtheria it has been learned that the administration of a minute dose of the so-called toxin-antitoxin will prevent diphtheria. It has recently been shown that scarlet fever can be prevented in a similar way. In spite of the discovery of toxin-antitoxin, the death rate from diphtheria in early life remains inexcusably high. Only when an enlightened public opinion demands preventive treatment for diphtheria and the early recognition and prompt treatment of the disease, if it occurs, will this scourge be wiped out.

The common cold, treated with such disdain by the public in general, has been found to be responsible for more loss of time, more suffering, more dangerous complications than any non-fatal ailment known to science. More research workers are engaged in an effort to determine its cause and cure than any other

one disease, with the exception of that scourge of humanity, cancer. There can be no question but that colds are contagious. The frequency with which a cold will travel through a family or a school has been observed too often to question its contagious nature. The suffering, the invalidism, the loss of time and even life, caused by colds and their manifold complications will continue unless greater care is exercised in avoiding the conditions that give rise to colds and favor the various dangerous complications.

During the prevalence of an epidemic of colds one should as far as possible avoid crowds and persons known to be afflicted with colds. One should avoid becoming chilled, tired or exhausted, all of which lowers bodily resistance.

Preventive measures include rational living, cold showers, well ventilated quarters and work rooms, and the avoidance of excesses in eating and drinking, late hours and fast living in general.

THE SCHOOL CHILD*

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A sane and sober man does not knowingly drive his car through an open drawbridge, ignoring the danger signals placed there for his protection, nor will he say to himself on the road when confronted by a red lantern: "They are just trying to fool me; I'll put one over on them by driving on as I please."

You say that is absurd—certainly, we will grant you that. But, Mr. Citizen, you are doing things every day that are just as absurd and just as dangerous, and you do them despite, and almost in defiance of, the advice of your physician and your health officials. Organized medicine and public health have always pointed out the danger spots to the public who, sad to say, have gone their merry way, utterly oblivious to danger apparently, until confronted by the grim results of their folly. Why not sit down and think the matter over? Are we in such a hurry that we cannot stop to consider the health and welfare of ourselves and our families?

The child is sent to school to prepare for life. Yet, if the child is not going to live, why waste the state's money on education? The whole scheme of education is predicated on the assumption that the child will live, and should be prepared for useful citizenship. The Board of Education, the Board of Health, and the medical profession feel that this investment should be protected, and with this in view we are calling it to your attention!

What parent would attempt to teach a child to swim and handicap the child by fettering his hands? The wise motorist would not contemplate a long trip without having his car gone over thoroughly by a competent mechanic! The wise parent will not expect the physically handicapped child to do as well in school as his normal playmates. Neither will the wise parent start the child on a nine months' journey without giving due consideration to the physical machine.

What are some of the things that should receive special attention? It is certainly necessary that the child's visual and auditory apparatus be functioning properly if we expect him to learn through the two most important receptive channels. The child with defective vision or defective hearing is greatly handicapped. Your child may have either or both of these handicaps without your realizing it. Why wait until he repeats a grade to find it out? Statistics show that more time is lost from school by children suffering from diseased tonsils (sore throat) than is lost from whooping cough or measles. The child rarely loses more than four weeks due to whooping cough and frequently less than two weeks due to measles. This represents a concise concrete loss combined, during that period while the child with the diseased tonsils may be losing a few days in each month following changes in the weather, simply stringing it out over a longer period of time. Do you realize that a large percentage of heart disease is directly traceable to diseased tonsils? That most of the deformities of rheumatism can be traced to the tonsil? Is all this necessary?

Does it cost any money when a child repeats a grade? Yes, it costs the State of Florida $48.00 a year, the parents a year of board and lodging and the child one year of future earning capacity. Most of the repeaters in school are children suffering from physical handicaps

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and especially from defective tonsils. This is an added expense to the parent and to the government, as well as a loss of precious time to the child. Again, is all of this necessary? ASK YOUR DOCTOR!

Then, there is communicable disease. Many parents have had the erroneous idea that it was necessary for the child to have this, that, and the other, and have frequently pushed their children into the measles and whooping cough with the intention of having it "over with," little realizing that the death rate was higher from measles and whooping cough than from diphtheria! I repeat—the death rate from measles and whooping cough is now higher than from diphtheria.

Measles can be prevented or the severity of the cases greatly modified. Diphtheria can be prevented by a single dose of toxoid, which should be given to every child after the sixth month of age, and the Schick test will definitely and positively assure you regarding the child's safety. Are you interested enough in your child's welfare to inquire about this? If so—SEE YOUR DOCTOR!

There is no excuse for smallpox. Naturally your child should be vaccinated against this disease. The ideal time for the initial vaccination is 10 days after birth, while the infant is too small to scratch and infect the vaccination site. The greatest degree of protection, other than actually having the disease, is acquired by two successful vaccinations. Many persons have the idea that their immunity or protection is in ratio to the size of the scar. Nothing could be further from the truth. The large scar simply indicates that the owner was indiscreet and acquired a secondary infection most likely from his or her own finger nails. One should not be too sure of an old vaccination site. The protection rarely lasts longer than 10 years in a great percentage of the people. Be re-vaccinated. If you are still immune it will not "take" any way and if it does "take," that is positive proof that your immunity had worn out. The old theory that a vaccination was good for seven years is absolutely without foundation! It may be good for seven months, seven years or seventy years. The figure seven has absolutely no authentic basis for existing in this relationship and probably was simply handed down as a superstition.

Talk these matters over with your physician. Make him your counselor and advisor during times of good health as well as times of sickness. Had you consulted him earlier, in many cases, probably a long illness could have been avoided.

How often we see children sent to school with faces flushed and running a high fever with an accompanying sore throat and headache, or other symptoms simply because the parent was so eager for the child to maintain attendance. Think how many other children might have been spared the contact and possible development of scarlet fever, measles or infantile paralysis, as the case may be, had the parent only been thoughtful enough to have called the Doctor! Parents, let me make a plea for your neighbors. *Do not send your child to school when he is not feeling well!* Infantile paralysis frequently starts like a mild common cold. Would you appreciate some parent exposing your child to that disease simply because they thought it was only a cold? No, you would say, "Why didn't they call a Doctor?", and justly so.

If health conditions are ever greatly improved in Florida, or anywhere for that matter, it must come through the efforts of an intelligent, cooperative public. The practicing physicians are doing their part; these broadcasts indicate that. Public health officials are doing all they can. Now, what are you doing? It is important to build up a "health conscious" attitude on the part of the public to take the place of the neglectful, careless one, which is altogether too prevalent! If you saw a sneak thief steal some trifling article from a neighbor's house would you spread the alarm? Certainly, you would. Yet, if you saw a violation of a health regulation, what would you do? The sneak thief stole a petty trifle that in all probability can be easily replaced, while the other criminal (shall I say that word? Why not? A criminal is one who breaks laws, is he not?) may be robbing you of health, even life, or perhaps robbing you of the life of persons near and dear to you!

Just a few things for you to think over.

To recapitulate: Your child is starting to school. We urge you to give the child a fair chance:

1. Have your Doctor examine your child and make sure that he or she enters school without a handicap.

2. Be sure that the child has been protected against smallpox, diphtheria and typhoid fever.
3. If the examination reveals defects, have all correctable defects attended to by competent medical, surgical and dental care.
4. Remember the Golden Rule: "Do unto your neighbor as you would have him do unto you." When your child is feeling bad call your Doctor before allowing the child to go to school and possibly expose many other children to some serious contagion.
5. Remember that a strong healthy physique is one of the best defenses against disease and especially against diseases like infantile paralysis and spinal meningitis. Call your Doctor and let him treat the colds and other disorders which may lower bodily resistance and make your child more susceptible to invasion by the virus of poliomyelitis and other dangerous diseases. Keep the physical stamina up to par and thus throw off many dangerous infections.

HYPERSENSITIVE PEOPLE*

S. C. Colley, M.D.,
Tavares.

When the patient with hay fever or asthma consults his doctor, why does the physician make a series of scratches on his arm and drop a different solution upon each scratch? And why does one of the scratches become red, swell and begin to itch? What has all that to do with sneezing, wheezing, and watery eyes? It is a long story—one which begins in the laboratory, the workshop of the scientist, and has ended in the office of the country doctor.

Some scientists study problems which are directly related to human life, to human ills and to human events. Others study science, as they say, for its own sake and call themselves pure scientists. A few years ago Dr. Ralph H. Major, while passing through a chemical laboratory, was somewhat startled to have a well-known chemist, a "pure" scientist, rush up to him and exclaim: "I have just made an important discovery, and, thank heavens, it has no practical application." Such a "pure" scientist must be very careful, for he can never tell when his discovery may have a very practical application. The history of medicine is filled with just such occurrences. The theory of today may be the fact of tomorrow, and the discovery in "pure" science may later have a direct bearing upon the lives of thousands of people. The subject of allergy or hypersensitiveness, illustrates in a striking fashion just such a turn of events.

In 1839 a French physiologist, Francois Magendie, injected a dog with a small quantity of egg albumen. No bad effects followed the injection. Later, however, he again injected the dog with the same dose of egg albumen, and it died quite suddenly. Magendie was much mystified. Egg albumen, so far as anyone knew was not a poison, yet it had produced fatal effects.

Some twenty-five years later a small boy of nine went to an old-time spelling bee in the country. In the evening he ate a hearty meal at a farm-house, and at the end of the meal buckwheat cakes were served. All of the company began eating the cakes with great relish, and the small boy took a bite of his cake. He had scarcely swallowed it before he felt an intense burning in his throat and stomach—"felt as if I had swallowed hot lead," he said. He immediately began to retch and became so short of breath that he was forced to run out of the house into the open air. His eyes became bloodshot, his face swollen and red, and his lips knotty with large hives.

He was very much frightened and decided to walk home. The night was very cold, but the cold air relieved his itching and burning skin, and after walking three miles through the snow to his home he felt much better. His mother thought that the attack was caused by playing too hard, but the boy felt sure the buckwheat cakes had caused the trouble. The following morning he was perfectly well.

Some time later the boy ate some corn cakes and had another attack. This seemed to show that corn cakes also could produce these symptoms but when the matter was investigated further, he found that the corn meal came from a mill where the corn had been ground on the same stones used for grinding buckwheat flour. He was then convinced that

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he was sensitive to buckwheat flour and resolved to avoid this item of diet carefully in the future. He was, however, not always successful in avoiding his enemy. If he ate corn cakes which had been cooked upon the same griddle as buckwheat cakes, he invariably had hives, pains in his throat and often vomiting. So he had to exclude all cakes from his menu unless he personally supervised their cooking.

For several years he thought he had the same sensitiveness for black pepper, for when he ate highly seasoned foods, as soups and turkey dressing, he had these attacks. To settle the point he brought home some pepper berries, had them ground at home and used them in his food. No unpleasant symptoms followed. Suspecting an adulteration in the black pepper of commerce, he sought out an agent of a large spice mill and asked him if such were the case. After considerable hesitation the agent admitted that his firm bought buckwheat hulls by the carload and after roasting and grinding them mixed them with spices and pepper. On one occasion he had a violent attack after eating some honey which he noticed was rather dark. When he investigated this honey he found it was made by bees who had fed upon buckwheat blossoms, and that this kind of honey was known commercially as "buckwheat" honey.

This gentleman, after forty-five years of adventure with buckwheat presented himself at the Johns Hopkins Hospital for observation. During those forty-five years much had been learned about just such cases. His arm was scratched slightly and one drop of an infusion of buckwheat was placed on the scarified area. After fifteen minutes the patient remarked: "The buckwheat is beginning to work." He complained of a tight feeling across his chest, began to cough like an asthmatic, and developed intense itching hives over his face, body and extremities.

This same phenomenon attracted next the attention of two physicians in Vienna—Clemens von Pirquet and Bela Schick. This is the same von Pirquet who later became one of the most famous child specialists in the world and whose recent tragic death caused such genuine grief in his native Austria. It is also the same Schick who was later to give his name to the Schick test, known, not only to the physician, but to every school teacher and mother in the country. At that time, however, they were both comparatively unknown young men working in the Children's Clinic in Vienna. They were treating children suffering from scarlet fever with a new serum which had been introduced for the treatment of this disease.

In treating these children with the serum, it was necessary to use very large amounts. They noted that about two weeks after the children had received the serum, some of them had sudden fever, chills, profuse eruption of hives, and severe joint pains. They found also that children who did not show this reaction after a single dose of serum, almost invariably had this reaction if they were later (in about two weeks) given a second dose of the serum. They called this condition "serum disease" and called it allergy, or the changed state, or "altered reaction."

Tuberculosis, as was well known, was not invariably fatal—there was good evidence that tubercular patients developed immune substances that fought the disease. Many years before, Robert Koch, the discoverer of the tubercle bacillus, had shown that, in growing, this bacillus formed a substance known as tuberculin. He even hoped at one time that the use of tuberculin would cure the disease. In this he was disappointed as we well know. Von Pirquet, however, showed that when a tubercular patient's skin is slightly scratched and a drop of tuberculin is applied to the abrasion, a local swelling and redness appears, much like that seen in his cases of serum sickness. This test is known as the von Pirquet test.

This simple test which made von Pirquet's name known in the medical world from Paris to Shanghai and from Tokio to New York, led to an application of this method in a great variety of disorders suspected of belonging to the same general class. The patient whose adventures with buckwheat cakes have been described showed, it may be recalled, a marked skin reaction when a single drop of buckwheat infusion was applied to the skin.

Many persons have long known that they had a sensitiveness to certain foods; strawberries are a classical example. Many persons have intense attacks of hives whenever they eat strawberries. Some people have the same reaction when they eat eggs. Fortunately,

these persons often discover their own sensitiveness and by avoiding the cause escape unpleasant after-effects. At times, however, the offending article of diet is not so readily discovered, and here the employment of these skin tests modeled after the Pirquet test have often demonstrated the offending substance responsible for the illness.

One of the best known of the various kinds of asthma is that long called by its victims as "horse asthma." Many sufferers with this complaint have known long that they had attacks of asthma whenever they came in contact with horses. I saw a very severe case of asthma develop in a man who spent the night in a small hotel. He remarked that for years he had known he was sensitive to horses, but had seen no horses at the hotel. The mystery was cleared up when it was found that a few years previous the basement of the hotel had been used as a livery stable. With the coming of the automobile the livery stable had been abandoned and the basement remodelled for storage rooms and a heating plant. Evidently all trace of the horse's presence had not been removed, for the guest on the third floor had an attack of asthma the first night he slept there. A skin test on this gentleman showed a marked reaction to horse-serum.

The patients sensitive to horse-serum, the sufferers from horse-asthma, often present a serious problem to the physician. Most of the antitoxins and serum used in contagious diseases contain horse-serum. If a patient who is subject to horse-asthma develops diphtheria and is given a dose of diphtheria antitoxin, he may have a very stormy time, and his physician may have some exceedingly anxious moments. The passing of the horse as a means of travel has removed a great menace to the sufferers from horse-asthma, but the development of antitoxins have produced a fresh hazard.

In addition to sensitiveness to horses, some people are sensitive to cattle, to sheep, hogs, dogs, cats, rabbits, mice, chickens, ducks and geese. Many individuals are known to be sensitive to chicken feathers and have attacks of asthma whenever they sleep on a feather pillow. Many patients long subject to asthmatic attacks have seen a complete disappearance of their symptoms when they abandoned the use of sleeping pillows.

One of the most important and widespread diseases due to allergy is hay hever. This disease seems to have been first described in 1819 by a London physician, John Bostock, who suffered from it in summer and gave it the name of "summer catarrh." For the greater part of a century it seemed to be a comparatively rare disease.

William Dunbar, who was the first to inaugurate the modern scientific study of this disease, considered it, at first, a product of modern culture. Working people and uncivilized nations, he stated, were seldom attacked by it, whereas nations possessing a high culture were most commonly affected. North America, he found, showed the greater number of cases.

In 1856, forty years before Dunbar began his experiments, Charles Blackley, a physician in Manchester, England, proved that pollen was the cause of hay fever. Blackley himself was a sufferer from the disease and found that if he collected pollens and applied them to his eyes or to his nose he could produce an attack. He also found that if he made a scratch on his skin and applied pollen, he had intense hives at this point. Later Helmholtz, also a sufferer from hay fever, examined his nasal secretions during an attack, and found bacteria present which at other times, when he was free from attacks, were not present. Helmholtz's, experiments were followed by others and for many years the bacterial theory of hay fever was generally accepted.

Dunbar began to suspect that there was something present in the blooming fields which caused asthma and began to collect the pollen and test it on persons susceptible to hay fever. Dunbar showed that these pollens produced attacks of hay fever. This was the final blow to the bacterial theory.

Since Dunbar's time hay fever has been intensively studied, particularly in this country, where it continues to show its prevalence. It is conservatively estimated that there are more than one million hay fever victims in this country and probably ten million persons who are predisposed and may develop the disease if they are exposed to too much pollen. The ailment is distinctly on the increase. Fifty years ago it was a rare disease: today it is exceedingly common.

The most prevalent type of hay fever seen

in this country is caused by golden-rod and ragweed which scatter their pollen in summer. Ragweed pollen can be easily carried fifteen miles in the wind and a single ragweed plant may shed millions of grains of pollen in twenty-four hours. The ease with which this pollen is borne by the wind calls attention to a very interesting adaptation in nature.

Another substance to which many individuals are sensitive is orris-root. This is very commonly employed in cosmetics, the use of which is widespread and is often a conspicuous feature of modern life. Wherever women are, there is an abundance of orris-root. Churches, theaters, schools, homes, business offices, even barber shops, have it in the air. The patient whose hay fever attacks are due to sleeping on feather pillows can easily change his feathers to something else, but what can the poor man do who is sensitive to orris-root? He cannot be told that he must avoid all women. Women who are sensitive to orris-root, as can be seen, are in even a more pitiable plight.

A very striking disease due to hypersensitiveness should be mentioned. This disease is called "giant urticaria" or "giant hives;" also a formidable term, "angioneurotic edema" is often employed. Patients subject to this affection often, without demonstrable cause, suddenly develop a marked swelling of the eyelids, of the lips, or of the hand. Sometimes the poor patient's face is so swollen that this friends scarcely recognize him. Unfortunately, the swelling is not limited to producing distressing symptoms of the face, but may involve the throat and larynx and produce sudden death from suffocation. Many patients of this disease are sensitive to certain foods and their avoidance brings complete relief. Their sensitiveness to such foods is shown when the application of them to a scratch on the skin provokes a local reaction.

What after all is the explanation of these various disorders described as allergic diseases? No theory yet proposed explains all the manifestations. Perhaps the best theory is that advanced by Vaughan.

In the normal animal, individual cells become specialists. When food is introduced into the intestinal tract, the intestinal cells secrete ferments which attack and split it up. When, therefore, horse-serum is introduced into the skin, the cells although not used to this process, form ferments which gradually destroy it. If ferment is formed in large amounts and if the animal receives a second injection of horse-serum, the serum is immediately attacked and broken up and poisonous substances are formed. These poisons produce the symptoms of allergic disease.

The actual substance responsible for the allergic phenomenon is unknown but there is considerable evidence that it may be histamine, a substance which an English physician, H. H. Dale, has shown is present in large amounts in most of the tissues of the body. Histamine in extremely small doses, when injected, produces hives, a fall in blood-pressure and shock-symptoms like those in allergy. It is a somewhat disquieting thought to recall that a man constantly carries in his tissues enough of this substance to kill a room full of people were it released. The release of a certain amount of this substance may be the cause of the symptoms.

Unsatisfactory as the theories are, treatment, as already indicated, is usually satisfactory. As in so many other diseases the physician must treat his patient when it is necessary and not wait for the explanation of the disease. Meanwhile the patient who is sensitive to foods, and heat or light must be protected from them.

THE ROMANCE OF MEDICINE*

Louis Orr, M.D.,
Orlando.

Medicine is the only world-wide profession following everywhere the same methods, actuated by the same ambitions, and pursuing the same ends.

For many years the Florida Medical Association has sought to offer, through the press and principally the radio, information on medical subjects that would be beneficial and informative to the public mind. The principal motive in this educational movement has been to more thoroughly acquaint the public with the symptoms, the diagnoses, and the various types of treatment of the more common diseases and afflictions of mankind. It has been an

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effort on the part of the Association to sound warnings of disease and symptoms, which perhaps if attended to early might result in prevention of untold suffering later in life. Sympathetic understanding of the public has been solicited for without this, the great battles now being waged against tuberculosis, heart disease and cancer can never be won. To be familiar with a disease would quite naturally seem to arouse curiosity as to its origin and history.

To read of the advancement of medicine from the dark ages to the modern era is to read of the greatest romance the world has ever known. From the beginning it has been fraught with ignorance and quackery; its progress encumbered with conflicting religious teachings; its martyrs persecuted for their beliefs which, however, have survived and made modern medicine the benefactor of all mankind. This progress can be divided into two distinct periods, the ancient and the modern, but even ages before the ancients came into being, primitive man carried out certain practices which might be called medicine in that evil spirits were driven from the body in an effort to relieve suffering. For all purposes, however, the only eras that need be considered are those founded upon historical fact; first, that of ancient medicine, and later of modern medicine.

Historians have discovered that as far back as 2250 B. C., medicine was recognized and practiced in Babylonia. In the ancient civilization of Egypt 5000 years B. C., even though a mixture of religion and superstition, a certain number of practical medical measures were carried out, for here we find the first use of a splint for a broken bone. To the Hebrews of antiquity must go full credit for being the first of all people to practice preventive medicine, personal hygiene, and sanitation. Their priests were the sanitary police and even in these modern times the priests are still practitioners of enforced personal sanitation. A pity it is that their wise practices have not become world-wide for much suffering from loathsome disease might be eliminated.

The first records of a scientific medical system are Greek in origin. Greek medicine was exhibited in its pure form from 500 B. C. till the rise of the Roman Empire. The principal localities of the development of medicine were in Asia Minor, and Sicily, with Athens as perhaps the chief center. Hippocrates, the great Greek physician, was the first to sit beside his patient to observe and record symptoms of disease. To him goes full credit for the art of diagnosis. After his time, civilization and medicine both declined. For the next 1800 years, no physician equalled Hippocrates. As a result of his work and efforts, he is today considered the father of modern medicine.

In the period of the Renaissance from 1453 to 1600, the important medical figure was Vesalius, the anatomist. Vesalius was born in a period when the invention of printing and world exploration brought about a knowledge of other countries and people which greatly aided the progress of medicine. As Vesalius worked at the dissection of the human body, Leonardo da Vinci founded the school of human art. The more he painted the more anatomy he needed to know. In this way anatomy and art developed hand in hand. Strangely enough, progress in this period was also fostered because of the ability of the students to better translate the works of Hippocrates of many years before. Shortly after this time, Italy became the land of many of the great scientists. Their names are not infrequently used to designate certain parts of the body. In the 16th and 17th centuries not only anatomy but pathology, the basic science of disease, and physiology, the basic science of health, began their development.

In the first of the 17th century, the great English speaking scientist, William Harvey, discovered the circulation of the blood. Harvey came to the absolute conclusion that the blood passed out through the arteries and back through the veins. It was at this time that the first microscope was invented and through it, the Italian physician, Malpighi, discovered the capillaries which carry the blood from the arteries to the veins and thus made Harvey's work complete.

The 16th century cannot be passed, however, without mentioning Paracelsus and Pare, one a physician and the other a surgeon. Paracelsus first analyzed drugs and mineral waters. He believed that nature cured diseases much more than did physicians and felt that too much meddling was dangerous. Pare was first an apprentice to a barber and later became an army surgeon and at the time of his death was the greatest surgeon of the day. He learned that wounds healed more rapidly when let alone than when treated too frequently. It was the custom at that time to treat gunshot wounds by pouring boiling oil in behind the bullet and when Pare's supply of oil gave out one day he found that next day his patients without the oil treatment were much better off. From this time on his fame became widespread. Pare is credited with the well-known expression, "I treated him, but God cured him."

In the 17th century, came the beginning of North American medicine. Cortez erected the first hospital in Mexico City in 1524, a beautiful building still standing. In this country, the first hospital was built in 1663 on Manhattan Island.

The 18th century, although not full of epoch-making discoveries, saw one of the greatest achievements of all times, the discovery of vaccination. It is this period of medicine that was dominated by theories and systems, by cults and creeds, but even so, some permanent progress was made. In 1752, Reaumer showed the effect of stomach juices on foods, and digestion thus became understandable. William Hewson, in 1710, first discovered the correct use of digitalis in treating diseases of the heart. The outstanding surgeon of this time was John Hunter, whose studies resulted in the present day operation for correction of club feet. In this century, sanitation and drainage were stressed, sewers were constructed, lepers were isolated, and gymnastic exercises were introduced.

The 19th century was destined to see great strides in scientific medicine for in this period preventive medicine and the control of infectious diseases developed. Blood letting by the open wound and by leeches became popular. In 1833, 40 million leeches were sent to France. It is said that our first President, George Washington, died from weakness produced by too much blood letting. From 1840 to 1850, we find diseases described as they were by Hippocrates many years before. Basedow described exophthalmic goiter. Stokes wrote on heart disease; Addison recognized pernicious anemia. During this decade, we find America making her first major medical contributions, the greatest of which was the discovery by Long and Morton of ether as an anesthetic for surgical operations. Before this time, the patient was held to the table by strong men and the surgeon performed as quickly as possible.

In 1860, the first principles of antisepsis were formulated by the English Quaker surgeon, Lister. He discovered that wounds exposed to the air became infected and that by adding carbolic acid to the wound, the infection was prevented. He first thought bacteria came from the air, but later discovered they came from the hands of the surgeons. From this discovery came aseptic surgery and surgeons thereafter were to wear gloves, gowns and a mask.

In the latter part of the 19th century, the work of Louis Pasteur, the man who has saved more lives than any other man, became known to the world, and pasteurization, a process of heating a fluid to a certain degree to prevent bacterial growth, became a universal procedure. Today the milk you drink is made safe by this process. In 1882, the German, Robert Koch, discovered the cause of tuberculosis. This discovery stimulated the later discovery of the germs of cholera, typhoid, diphtheria, tetanus, and meningitis. Modern methods of sanitation, purification of milk, and sewage disposal followed closely behind these discoveries. Almost at once, infant mortality began to decline.

With the dawn of the 20th century, we find the beginning of phenomenal discoveries and inventions which hastened the progress of scientific medicine. Many of you who are listening can remember the discovery of the x-ray by William Conrad Roentgen in 1905. Everyone knows of the

splendid work of Madam Curie and her husband in the discovery of radium and how the world believed that at last a cure for cancer had been found. The germ causing the greatest scourge to mankind, syphilis, was isolated in 1905 by the young German, Shaudin. In 1910 a fellow-countryman, Erlich, completed his 606th experiment and at last found a specific cure for that dreaded disease. To Banting and Best, of Canada, we are indebted for the discovery of insulin, which prolongs and makes comfortable the lives of those afflicted with diabetes. Yellow fever, malaria, and many other diseases were found to be caused by the germ being transmitted by means of the mosquito. Drugs and measures of control were at that time discovered which both cure and prevent these very commonly fatal diseases. Serums and vaccines have been developed which will, if used in time, invariably cure diphtheria, lockjaw, tetanus, and other serious diseases. Tuberculosis, in most cases, now means only an enforced rest in a suitable climate. Complete recovery is the usual result. It is no longer called "The Captain of the Men of Death." Those suffering from pernicious anemia owe their lives to the splendid work of Minot, Murphy and Whipple, who found that the disease responded almost miraculously to the administration of liver extract. These scientists have just recently been awarded the Nobel prize in medicine for this outstanding work.

Modern surgery has advanced rapidly in the past few years. Those who have certain types of heart disease can hope for relief by having the thyroid gland entirely removed. The small glands near the thyroid, called parathyroids, which control calcium salts of the body, can now be transplanted successfully from one patient to another. Successful operations on various parts of the brain are an everyday occurrence. Hopeless cripples have been made useful citizens by the marvels of orthopedic surgery. Proper exercises are overcoming the dread effects of infantile paralysis. Now, even if one's lungs are completely paralyzed, one may live indefinitely in an artificial respirator.

Progress in the treatment and the control of cancer, although little known to the public, is making great headway. Millions of dollars are used each year for scientific research on this dreaded disease. At any time a treatment may be discovered that will completely eradicate this cause of such a high yearly death rate.

Modern medicine has thus emerged from an age of mystery and misunderstanding to an age of mathematical exactness and scientific control. In the hands of its practitioners are the instruments of precision which, when deftly applied, yield splendid results and relieve untold human suffering. What new discoveries in the field of medicine and surgery are to come, we do not know, but if the progress in the science of medicine is such in the future as it has been in the past, the joys of living will be untold in their anticipation and old age will indeed be a pleasant and just compensation for a life of usefulness and good health.

THE CHRISTIAN FATHERS AND MEDICINE*

S. A. Shoemaker, M.D.,
Orlando.

In every age the study and practice of medicine has been attended by an element of romance and heroism. Christ was the outstanding healer of all time, and was called "The Great Physician." The rapid recognition of His virtue and power was largely due to His ability and willingness to heal. Sacred history records that He healed all that came to Him for healing of whatever diseases they had. The ablest of the Gospel writers is St. Luke, who was called the "beloved physician."

Whenever any nation took on civilization it invariably gave some attention to the relief of suffering. In the earlier centuries medicine was merely an art, not being elevated to the dignity of a science until later years. There has always been some relationship between religion and medicine: the former being the healing of the soul and

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the latter the healing of the body. The two go well together.

As the peoples of the earth progressed in civilization they gave more attention to the study of medicine and of late years the healing art has been elevated to one of the most dignified professions and has been placed upon the firm foundation of science.

Among the early men who gave attention to medicine was Titus Clemens who was a student of Plato and the Alexandrian School of Philosophy, about the second century of the Christian era. He studied the ethics of Christianity and published a large number of books, chiefly on philosophic and medical topics. Hieronymus was an early medical writer who wove into his teachings religion and philosophy. His writings were somewhat similar to those of Clemens. The writings of Hieronymus might be summarized in the following words: "Whoever is ill recovers health only through a restricted expenditure of energy, a rigid mode of living and a meager diet." He and other Christian fathers preached much against drinking and overeating, the common vices of their times; and it is most singular that it required the lapse of nearly 2,000 years before a single nation saw the wisdom of their teachings, and had the courage to incorporate them into legislative statutes.

Those doctors whose names stand out in the dim pages of history, the men who were leaders of their day in Babylon, Egypt, Greece and Rome, as well as the Christian Fathers of the early Church saw clearly the importance of the above doctrine and followed it. They realized the importance of sacrifice and service. Those were the lodestones which guided them to the study and practice of medicine, and their convictions of life compelled them to serve humanity. Unfortunately their services were not always appreciated, and their teachings were often scorned and forgotten. How much richer, stronger, and better our civilization would be today if the teachings of those philosophers of antiquity had been heeded! The historian says: "It is difficult to picture how fine the physical and mental qualities of the European peoples would have been if prohibition and diet restrictions had been enforced since the time of Hippocrates and Galen showed the injuries done to mankind by intemperance in eating and drinking. Throughout the ages, the greatest medical authorities have shown that those excesses are the greatest hindrance to the health of people and the progress of civilization and today these things have to be preached as frequently as ever."

THE DOCTOR'S ALTRUISTIC SERVICE

The physician cannot be a hermit. A hermit is never a complete man. We are essentially social units compelled by inherent instincts to enter into close social relationships. We must be a strong, pulsating, active part of the community in which our life is cast, receiving and giving service. No member of any community does so, more than the doctor. In Asia, Africa, and Australia, as well as in America, we find doctors excelling all others in rendering service. As we glance through the musty pages of the records of the remote past, we find the doctor doing this same sterling work. Social conditions might be in a precarious state and culture slight, still the family doctor retained a heart of gold, and completed his ministering to the sick regardless of physical or political obstacles. In all history we have never found the doctor failing in service. There is to him something deeper in life than mere leisure and luxury. Besides the universal craving for religion which never forsakes mankind, there is in most people a strong desire for social service. Not all are capable of rendering it. The doctor and the churchman are peculiarly fitted for doing it, and when their dispositions lead them to utilize these privileges, they become the greatest benefactors of their day. There is a yearning for sympathy firmly planted in humanity, and it is that which acts as a lodestar bidding the doctor stand firmly upon the basic fundamentals of life, and grace his community with acts of service, whether such service is recognized or quickly forgotten. These are the forces which caused men like Hippocrates and Galen to live laborious days; they were the impulses which caused the doctor to assist in shaping the development of civilization and ethics. Upon these

were based the promotion of charitable enterprises, like hospitals, foundling homes, asylums, and sanitaria. All of these are offsprings of self sacrifice and altruism, and the doctor has always been among their ardent champions.

The Christian Fathers usually delivered their teachings in plain, direct, and forceful style, as is evidenced in the following by Clemens: "Truly, some men live that they may eat, as the irrational creatures whose life is their stomach and nothing else." But a wise teacher advises us to eat that we may live. For neither is food our business, nor is pleasure our aim. Wherefore, there is discrimination to be employed in reference to food. It is to be simple, truly plain, as ministering to life that it may conduce to health and strength. High qualities of thought and character never accrue from over feeding, ease and luxury.

Antiphanes, the Delian physician, asserted that rich viands are the cause of much sickness. He said: "The gluttons seem absolutely to sweep the world with a dragnet to gratify their luxurious tastes. They surround themselves with hissing frying pans, and wear their lives away gratifying an avaricious palate. The eating man seems to be all jaw and stomach." Thus spoke Antiphanes centuries ago and his words are as true now as then. Clemens in philosophizing on drinks and diets compares the havoc of wines to that of shipwreck except that the former is more insidious than the latter, but both will swamp soul and body and constitute major disasters. Nemesios gained renown for suggesting the dominance of mind over body. He also anticipated Harvey's discovery of the circulation of the blood.

Early medical men suffered much persecution for their teachings. They held the torch of intelligence high among a people who were little inclined to move forward in their thinking. They were persecuted for teaching advanced ideas in medicine and health. In the days of Galen the laws forbade the dissection of human bodies; therefore, this great student of anatomy was compelled to confine his dissecting activities to apes. In many lands even the dissection of lower animals was forbidden by law, under the superstitious theory of transmigration of the soul. They feared Dr. Galen or some other physician might injure the soul of one of their departed friends in the process of dissecting an ape or a cat. Similar ideas are still held in certain lands where the light of Christ's Gospel has not penetrated the mental and moral gloom.

MINISTERS PRACTICE MEDICINE

In the early centuries of the Christian era most of the doctors who were not Christians gave themselves over to luxury, ease and self-indulgence to the neglect of the public. This forced ministers of the gospel to study medicine, and many of them applied the healing art. One of them said: "Christ is the greatest figure in history, because of His reality; and He still has the power, because of His reality, to make men fall in love with Him in spite of all their prejudices. A Christian is one who has fallen in love with Christ; and the peculiarity of the Christian religion and of Christian character springs out of this fact."

The masses in those times had little or no vision. The men of inspiration were in the Church, and through their foresight history has been rewarded by the preservation of the principal medical works of antiquity as well as the handing down of the practice of medicine. Many were crude materialists and worshipped only self and pleasure. Such a people could produce only mediocre men, and history finds few artists, literary men, inventors, or surgeons outside of the Church.

The medical classics of the Greeks and Alexandrians, as well as the writings of the Christian Fathers, and the literary men of Greece and Rome are replete with facts bearing out this statement. It was high inspirations that led men to preserve medical records for all time.

CONSTRUCTIVE MEDICAL WORK

Throughout the long period of the Stone Age medical lore was perpetuated by oral traditions. In Babylon and Egypt, when hieroglyphic writings were introduced, medical learning was committed to writing.

The hieroglyphic records of the scribes, the clinical notes of the doctors, and the early textbooks on medicine, served to broaden the minds of medical students. Later libraries were established and finally schools for the instruction of doctors were founded. These schools developed outstanding, vigorous thinkers like Asklepeades, Hippocrates and Galen and subsequently the Church Fathers. Throughout the centuries since the founding of Babylon constructive thinkers have carried the torch of medical thinking higher and higher.

While the early Christian Fathers made no great strides in advancing medical science they did preserve and hand down to posterity the discoveries and teachings of Hippocrates, Galen and other ancient medical thinkers. They were busy disseminating the fundamental tenets of Christ's life and teaching, viz: love, mercy and truth. Compassion and consideration for the physically and mentally weak and maimed was their idea. Before Christ's teaching gripped the world there were no hospitals and almshouses. In no country were these institutions of love and mercy established until the people were first enlightened by the Gospel of the Son of God. The sick, the maimed, the blind were cast out to die or take their chances with the elements. Their care was auctioned off, and they were farmed out to the cruel mercies of the lowest bidder. The dissemination of the Gospel of Christ changed all this. Under His teaching the helping hand of mercy is extended to those in need. The Christian Fathers played a large role in bringing about this change.

In almost every century one or more men rise to carry learning onward and forward and advance the general welfare of humanity. While ordinary life teems thoughtlessly on in town and country, there is always some man living laboriously to lift up the masses and the professions to higher planes. The history of medicine illustrates this most markedly. They rise and do great work in seeking and publishing the truth for subsequent centuries to digest. Such men as Hippocrates, Celsus, and Galen bequeathed to the world a rich legacy of sound philosophy and medical teaching which will serve succeeding generations as long as civilization shall endure. They did their work well and the responsibility is ours to cherish and preserve the rich inheritance they handed down to us. We must emulate their high ideals and carry on in their stead.

THE EARLY TEACHINGS IN ANATOMY AND THE CIRCULATION OF THE BLOOD*

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Our knowledge of anatomy began with the early Greeks, the 15th century B. C. In Hippocrates' time, what anatomical knowledge there was, was gained by animal dissection. It is probable that Hippocrates possessed only a superficial knowledge of the position and structure of the internal organs and even less idea of the physiology or function of these organs. Aristotle left no branch of learning unexplored and he extended human knowledge in many directions, more particularly in his investigations of the lower animals. Through his connection with the great conqueror, Alexander, he was able to collect the bodies of beasts, hitherto not put to scientific investigation and dissection. It is equally certain that he never examined the bodies of dead human beings. He founded the science of comparative anatomy and left a mark on human thought that has endured to this day.

Herophilus, as a result of his researches, was a prolific contributor to anatomical knowledge. As a result of his studies of the nervous system he gave the first description of the large blood-vessels or venous sinuses contained in the covering of the brain and their meeting place, at the base of the skull cavity, which bears his name—the torcular Herophili. He was the first to point out that there were two types of nerves; one carrying sensory impulses toward the brain, the other carrying motor impulses from the brain to the muscles. He also described some of the parts of the brain itself, especially one of its cavities,—the fourth ventricle. Dissecting the human eye, he described the retinal coat of the eye-

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ball, the lense. He gave names to a small bone in the neck, the hyoid bone; the first portion of the small intestine, the duodenum; and the gland surrounding the outlet of the male bladder, the prostate. In addition to his anatomical work, Herophilus was a celebrated and respected clinician. He gave great attention to the pulse, emphasizing the differences which occurred in rate, regularity, force and amplitude.

The scientific medicine of the fifth to the second centuries B. C. was built on a true clinical experience with disease, and the Alexandrian School, on a practical investigation of human anatomy and on the vivisection of animals.

In the second group were the alleged followers of Herophilus, who wandered into sophistries rather than follow the study of anatomy and the teaching of the School of Cos and of their patron. Galen, starting with the anatomical knowledge contributed by the Alexandrian School, enlarged upon this knowledge and made still greater contributions. For his own anatomical research, he resorted to dissection and vivisection of animals, particularly of apes, monkeys, pigs and dogs. Dissection of the human body was regarded by the Romans, as it had been by the Greeks, as sacrilegious. For this reason, Galen founded his anatomical knowledge entirely on the anatomy of animals. Galen's most valuable anatomical work was done in investigation of the nervous system. He described the meninges or coverings of the brain, gave permanent names to several parts of the brain, and showed that nerves may be purely conductors of sensory impulses to the brain, or purely conductors of motor impulses to the muscles from the brain, or that they might be a mixture of both. Nerves may originate in the brain or in the spinal cord, and of the twelve pairs, called cranial nerves, originating in the brain itself, Galen described and named seven. He also gave good descriptions of some of the heart valves. But he held that the veins originated in the liver, that the expansion not the contraction of the heart was its important function and that there were minute pores between the chambers of the right and left heart through which blood passed. While he asserted that the arteries and veins communicated by means of minute branches and thus showed his knowledge of one of the essentials of the law of the circulation he seems not to have even suspected the the blood circulated. When Harvey described the circulation of the blood fourteen hundred years later, one of the greatest obstacles in obtaining credence for his demonstration was the fact that it was contrary to Galen's teachings.

Anatomy and physiology at Salernum were taught according to the work of Galen. Some of the members of the school published elementary works on anatomy founded on the dissection of pigs. Treatment rested largely upon the Hippocratic method based on experience and common sense measures. In diagnosis, emphasis was placed upon inference drawn from the character of the pulse and of the urine. These inferences in the light of the knowledge of the present day were largely erroneous. Anatomy was taught from the dissection of the human body only in Italy, at Bologna by Mundinus as edited by Ketham and printed in 1494. It shows the professor reading from his own writings or from some earlier author, ex cathedra, while a prosector demonstrates the anatomical findings on a body laid out on a table below the reading desk of the master teacher.

The immediate followers of Mundinus edited his book and incorporated their own ideas, but only a few new discoveries, which was far simpler, than to present an entirely new description of the human body, in accordance with their own observations. It would seem that these early anatomists considered any deviation from the teachings of Galen which might be found, an exception and not the rule, or else they were so imbued with the teachings of Galen that they described what he had described rather than what they really saw. Such an observer was John Ketham, a German, who lived at Venice, and who printed an edition of Mundinus in 1492. The illustrations are inaccurate and roughly drawn, but show that the artist had seen the structures which he portrayed. Ketham's book, Fasciculus Medicinae, was published in several editions between 1492 and 1513.

Dissection of the human body in Italy was not confined to a few medical schools and physicians. The early sixteenth century saw the highest development of painting and en-

graving, both on wood and copper. The painters, Leonardo da Vinci, Marc Antonio, Michelangelo, Raphael, and Titian in Italy and Albrecht Durer in Germany, flourished during this period. Leonardo da Vinci left behind him many anatomical drawings which present an accurate picture of dissections of muscles and of the internal organs in many respects superior to the later publications of Vesalius and other medical anatomists.

Outside of Italy the teaching of anatomy was carried on in all schools on the basis of the writings of Galen. Jacobus Sylvius was professor at Paris and became celebrated for his brilliant lectures on anatomy, which however, did not go beyond the teaching of inherited medicine. Many celebrated investigators began their anatomical studies in the lecture room. Versalius, Servetus and Charles Etienne were among the number. The securing of bodies for dissection was a very difficult problem for the aspiring investigators of anatomy in the sixteenth century.

The Anatomy of Versalius presents a new departure in the making of medical books. It is well printed and the illustrations are of a distinctly artistic character. The skeleton and dissections of the muscles are presented in detail, but also as a portrayal of the whole body. These drawings represent a man always standing in the foreground with a background representing a landscape including trees and buildings and distant hills. If one looks at the landscape, it is found that a series of twelve illustrations can be pieced together to make a continuous panorama, one plate following after another, as if engraved upon one wood-block and subsequently separated. The division of the plates is such that trees and buildings are cut in two, the only object of the artist being to center the anatomical presentation of the human body in its various stages of dissection. It would seem as if the author and artist were planning to be able to claim that the drawings were artistic and not anatomical, for anatomists had previously got into trouble with the authorities by their zeal in adding to their anatomical knowledge by dissection. Charges of heresy were not infrequent against the profession at this time. Versalius in spite of his great addition to anatomical knowledge, failed absolutely to understand or grasp any idea of the circulation of the blood.

The influence of Versalius on anatomical illustrations continued for many years. In 1685 Gottfried Bidloo, of Amsterdam, published his Anatomi Corporis Humani, illustrated by plates of the lines of those of Versalius. These were re-engraved on copper by the artist, Gerard Lairesse, and are done more artistically than with references to accuracy of anatomical detail. The Bidloo plates were used by Wm. Cowper of London in his Anatomy of Human Bodies, published at Oxford in 1698, which fact caused a bitter controversy. The original opposition to the book of Versalius brought up the question of the dissection of the human body, and in 1556 the Emperor Charles V referred the matter to the theological faculty at Salamanca and asked for a ruling as to the orthodoxy of the practice. It was decided by those representatives of the Church that anatomical dissection by physicians for the benefit and teaching of medicine was permissible. It was many years however, before anatomical investigation became at all general. In fact there is still a widespread opposition to the examination of the bodies of the dead to determine the exact cause of death, and the advance of medicine is hampered today by that prejudice.

Before Harvey, the men whose ideas had the greatest influence on the prevailing conception of the physiology of the blood were Erasistratus and Galen. Erasistratus considered that the air was drawn into the left ventricle from the lungs and pumped from it through the arteries to the tissues; that in health the arteries contained only air, and that the veins contained only blood; that there were communications between the fine branches of the arteries and of the veins, and that in abnormal conditions of disease, blood escaped from the veins into the arteries. Galen disproved the theory of Erasistratus, that the arteries contained air. He considered that the veins originated in the liver; that the arteries originated in the heart; that the liver supplied the blood with nutriment and that the left ventricle of the heart supplied it with a hypothetical vital spirit just as essential as nutriment. He traced the blood by way of the veins from the liver through the heart to the lungs. But since he admitted that the lungs must have vital spirit, as well as nutriment and since he was in ignorance of the pulmonary circulation, he made his theory tenable by

stating that there were minute pores by which blood containing vital spirit entered the right from the left heart. As he said the pores were invisible, it was difficult to prove or disprove his theory.

Another of Galen's fallacies was his contention that the heart influenced the motion of the blood not by its contraction or pumping force but by its dilation or suction. It seemed to be his idea, that there was an ebb and flow of blood between the liver and heart on the one hand, and the tissues on the other. The nearest approach to an idea of the circulation of the blood in Galen is found in the description of the route by which a drug given to influence a condition of the lungs would reach that organ upon being sufflated. Galen says for a drug to arrive at the lung, it is necessary to take the following course: from the mouth into the pharnyx and esophagus to the stomach and small intestines, being absorbed by the veins of the mesentery, it is transferred to the veins on the under surface of the liver, then into the vena cava, the right side of the heart, and finally to the lung. There is no word in Galen of any return circulation from the lung to the heart. Describing the nourishment of the general tissues of the body, Galen states that the nourishment must in the same way be supplied by the veins from the liver, and again there is no suspicion of any return flow. To equalize the circulation, Galen invented the non-existent pores in the septum of the heart. Galen knew nothing of the physiological uses of the inspired and expired air, and gave as the only explanation of respiration that it was necessary to cool the blood, which would become overheated from the heat generated in the heart itself.

Wm. Harvey was born at Folkestone, Kent, in 1578. He was a small man, "easy and graceful of movement" with piercing black eyes and a quick temper, was physician and friend to many men of rank and distinction. In 1628 he published a book on the circulation called De Motu Cordis et Sanguinis. The book was published in Latin at Frankfort, not so much, because it would cause less stir if published abroad as that a book-fair in that city in that year offered special facilities for publication.

Today the average layman knows the blood circulates in the body and has a rough understanding of how this is accomplished. He knows, for instance, that the heart acts as a pump, that arteries carry the blood from the heart; that the veins carry blood to it; that the heart is divided into right and left chambers, which are in turn again subdivided into upper chambers or auricles and the lower chambers or ventricles. He can trace the course of the blood from the left ventricle into the large artery, or aorta, and knows that it is distributed to all parts of the body by branches of this vessel; that these branches become smaller and smaller until they divide into microscopic network of fine vessels which connect (anastomose) with similar small branches of the venous system. He knows that the blood is collected from the small into the larger and larger veins until it reaches the large vein of the abdomen (inferior vena cava) or the large vein in the upper chest (superior vena cava) and that these two veins empty the blood into the upper chamber of the right heart from which it enters the lower part to be pumped into the lungs. Here it goes through the same division into the small vessels, is recollected and carried back to the upper part of the left heart where it enters the lower part or left ventricle and thus completes its circulation and starts again on the same journey. He understands also that while in the lungs the blood takes oxygen from the inspired air and gives off carbon dioxide.

Harvey began to enunciate the doctrine of the circulation of the blood in 1616. He did not publish his views until twelve years later when his book was published at Frankfort in Latin. This delay in the publishing of his doctrine was due to his recognition of the "attachment of man to custom and authority," and his realization of the hostility and criticism, which would result from the effort to advance novel opinions at variance with the accepted views. In his introduction, he points out the shortcomings of some of the prevailing views on the action and uses of the blood, and speaks of the hesitancy and reluctance he feels in venturing to arouse the inevitable hostility and criticism which must follow the introduction of new ideas. He then proceeds to outline the steps which have led him to his conclusions, supporting them with demonstrations and experiments. The work is written in extraordinarily clear and concise language.

The argumentation is impressively logical. Except in a few places, where he uses the physiological terms of the day, the description seems thoroughly modern.

MEDICAL ETHICS*

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From the beginning of medicine, the importance of medical ethics has been recognized. In 450 B. C. Hippocrates wrote an oath which contained many fundamental morals that have been brought down to the present and on which the principles of ethics of the American Medical Association are based today. It is thought that Hippocrates got much inspiration and thought from Egyptian physicians who lived some two centuries before his day. Hence, the beginning of medical ethics is not known definitely.

I think we will agree that the most important thing in an individual or in an institution is character, and that character is based on the fundamental conception of what is right and what is wrong. During the latter part of the senior year each medical student receives a little pamphlet entitled "Principles of Medical Ethics."

The "Principles of Ethics" of the American Medical Association is the biblical instruction which endeavors and attempts to make a Christian out of a man in the practice of medicine. Yet the ethics of the profession are often misunderstood by the laity. They seem to think that ethics are some sort of a secret code or a trust by which we attempt to perpetuate our profession and make it lucrative. As a matter of fact, we may be a trust, but the only one I ever knew that looked after other people. There is, underlying all principles of ethics, a reason—a reason which will meet the approval of any honest thinking man if he understands it. The trouble has been often that when our principles are attacked from the outside, we individually do not know enough about what the principles of ethics mean ourselves, to answer the arguments.

"The Principles of Ethics" as it is called, is a short presentation in three chapters. 1. The duties of physicians to their patients. 2. Duties of physicians to fellow practitioners. 3. Duties of the profession to the public.

It is, as you see, an effort on the part of the profession and intelligent elements of medicine to conserve the idealism of the medical past. It seeks to elevate the standard of practice and scientific attainments of gentlemanly and moral conduct, for the benefit of the patient first of all, for the mutual instruction and elevation of the profession and in the interest of the public as a whole.

From the oath of Hippocrates, we quote the following: "I will follow the system of regime which, according to my ability and judgment, I consider to the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will not give to a woman a pessary to produce abortion. With purity and with holiness, I will pass my life and practice my art. Into whatever houses I enter, I will go into them for the benefit of the sick." Could anything be finer? And remember this was 450 B. C.

There is, perhaps, no profession upon which as much depends on faith. The merchant who has on his shelves various articles for sale, can exhibit what he has, and the prospective purchaser can look at what he is buying. But the prospective purchaser who looks into the eye of a doctor has no means of knowing the quality of material behind that face. If you see a man and classify him as a doctor, you do not know as you look at him, how absolutely competent he may be. However, you called him as your doctor, and you have to accept him absolutely on faith. There is no way in which the medical man can absolutely prove to anybody his capacity for what he undertakes. It is essential, therefore, that the basis of relationship of medical men with the outside world in their services is the element of faith.

The medical profession, if it expects to deserve and hold the confidence of the people, must measure up to that fundamental by proper preparation, and integrity in character. The code of ethics exhibits these principles. One of the chief duties of a physician is to seek to improve whatever talent he may have, by every legitimate means at his command, in order that he may be better prepared to discharge the obligation he owes to himself, to

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his profession and to his fellowman, as we shall find as we proceed with the discussion of this subject.

It is always laudable for a physician to get the best there is in the science of medicine, and this can be done by honest and industrious application to study. The cultivation of friendship in the profession broadens and makes a man better qualified through discussion of his cases. Every doctor owes it to himself and his clientele to join his medical society and attend regular meetings in order to keep himself abreast of the scientific advances in medicine.

Patience and delicacy should characterize all the acts of a physician. The confidence concerning individual or domestic life entrusted by a patient to a physician and the defects of disposition or flaws of character observed in patients during medical attendance, should be held as a trust and should never be revealed except when required by the laws of the State.

A physician should give timely notice of dangerous manifestations of the disease to the friends of the patient. He should neither exaggerate nor minimize the gravity of the patient's condition. He should assure himself that the patient or his friends have such knowledge of the patient's condition as will serve the best interest of the patient and the family. A doctor should never advise an operation unless he would want the same operation performed on himself under the same circumstances.

It is unprofessional to receive remuneration from patients for surgical instruments or medicine. It is unprofessional for a physician to assist unqualified persons to evade legal restrictions, governing the practice of medicine; it is equally unethical to prescribe or dispense secret medicines or other secret agents, or manufacture or promote their use in any way. A doctor owes it to himself, family and patients to put his practice on a sound basis so that he can keep abreast of the times with books, instruments and postgraduate work.

It is also necessary to educate the public to a proper consideration of the doctor's working hours and observance of periods of relaxation and diversion which will materially increase his efficiency and longevity.

Every medical man has been asked why the medical profession does not believe in advertising. To this I will reply, there are several good reasons. In the first place, advertising from the standpoint of a doctor is, to say the least, poor taste. If I advertise as a merchant that I have on sale today a fine piece of silk or certain furniture, or if I advertise I have a splendid bird dog pup I want to sell, I am advertising something material and outside myself, and you can come, look at it, and judge for yourself. When a doctor advertises he essentially advertises the superiority of his brain. We, at least, do not particularly enjoy hearing a man say, "I am the smartest lawyer in Florida" or "I am the finest doctor." "I know more than doctor Smith." It is poor taste for a man to advertise his mental capacity. Second: if it is correct for one to advertise, it is equally correct for all to advertise. It is a privilege that any can use. If advertising were universally accepted, it would reduce a dignified profession to a joke. There are about one hundred and fifty physicians in Tampa. Suppose you picked up the Tampa Morning Tribune and read the advertisements of one hundred and fifty physicians, would it not be a joke? Yet if it is good for one to advertise it is for another. Next, if I advertise, I advertise something which is either the truth or it is not. If I say I am smarter than Dr. Smith and I can do better surgery, or I have secret methods, or that I have discovered a cure for tuberculosis but I am not giving my formula to the public, one of two things is true. Either I am claiming to do something which I cannot do or I am a plain liar, because, as a matter of fact, there are few doctors that possess any essential virtues or knowledge apart from common knowledge of the profession.

Most doctors as advertisers, succeed because of their scientific lying. Suppose, on the other hand, we say a man advertises: he does not lie: he tells the truth. Suppose it happens that some genius has made a discovery by which he can cure a certain disease. We say, therefore, why should not that man take advantage of that thing to his own profit? It is his mental effort.

The principles of ethics of the American Medical Association intend that a man shall be a Christian first and not a commercial agent. The principles of ethics require that, if I happen to discover something which is

capable of saving a single human life, or alleviating the suffering of a single person, it is my obligation, as a humanitarian, to give that discovery the widest publicity so it may reach people all over the world. The result is when I advertise, I either am a liar or lack that thing that makes a Christian out of a gentleman.

Thus it is with all principles of ethics. There is underlying a reason and a rational one.

AMERICA'S MENACE*

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Fort Myers.

FOREWORD

The majority of the facts and figures herein contained was obtained from the original article written by Dr. Thomas Parran, Surgeon General, United States Board of Public Health, in the July issue of Graphic Survey. The facts were stated in such a clear, concise and easily understandable manner for the laity that I have taken this opportunity to pass them on in the original language.

F. D. Bartleson, M. D.

Throughout the ages, mankind has been assailed by war, famines, plagues, pestilences, hurricanes, diseases of every nature, and varied other allied menaces, which have been a detriment to the welfare of our great civilization. In our midst today is a menace more horrifying than war, more devastating than fire, and more ravishing than famine. This menace is greatest of plagues and pestilences. America's menace of today and tomorrow is syphilis.

We of America, according to the history of medicine, are accredited with an equal share in the source of syphilis. Two schools of opinion as to its true origin and antiquity have developed, one believing that it occurred in Europe prior to the discovery of America, the other holding that it was unknown in Europe until after 1492, and that it was introduced into Europe from America by some of Columbus' returning sailors. It is certain that syphilis has spread rapidly throughout the world since this time. Hundreds of different names have been applied to it, of which syphilis, lues venera and the great pox are the principal ones which have come down to us.

Syphilis is a contagious disease, characterized by widespread involvement of the tissues of the body and not infrequently leading to permanent anatomic damage and even death. According to the late Dr. Osler, syphilis is protean in its manifestations. It is a plague that disables half a million Americans a year; a plague that is wrecking lives, shattering homes and filling institutions all over the land with its insane, blind, feebleminded or unemployable victims—that is syphilis. It bids fair to become the greatest American disease.

As a matter of comparison, let's pause for a moment and compare the incidence of syphilis with that of other diseases. Let me repeat, in 1934 syphilis disabled more than five hundred thousand Americans. There is more of it than measles, twice as much as scarlet fever, three times as much as tuberculosis, ten times as much as diphtheria. It is a plague that does a hundred times as much damage as the dreaded infantile paralysis.

We have been much concerned in the past about the number of automobile accidents in this country. According to the report of the National Safety Council, during the year 1934 there were only 107,000 cases of permanent disability, while for the same period the disability caused by syphilis was five times greater. It is responsible for more than 10 per cent of all insanity, 18 per cent of all diseases of the heart and blood vessels, for many of the stillbirths and the deaths of babies in the first few weeks of life. There is reason to believe that if all conditions due to syphilis were reported as such, it would be found the leading cause of death in the United States.

There are no explosive outbreaks of syphilis. It occurs in magnitude of sporadic epidemics, throught single infections by personal contact from victim to victim. The patient usually knows from whom the disease was contracted. Usually sex contact is involved, although an abundance of cases are on record in which the disease has been incurred from kissing, from the

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use of a recently soiled drinking cup, napkin or handkerchief; from a pipe or cigarette; in receiving services from a diseased person, such as a nursemaid, barber, or beauty shop operator; and from giving services, such as those of a dentist, doctor, or nurse, to a diseased person. The ease and rapidity of spread of this disease, for example, by kissing, is shown by the following incident. In an eastern state recently the health officers traced seventeen cases of syphilis infection to a party at which kissing games were played and in which two infected, but socially desirable, young men, participated.

Apparently a gradual but fundamental change is taking place in the view which health authorities, the medical profession, and the general public have of the various problems surrounding syphilis. We are passing through a period of evolution not dissimilar to that which occurred in the campaign against tuberculosis. There was a time when tuberculosis was regarded as a disgrace and the unfortunate victim of this disease was ashamed of his affliction. "Consumption" somehow cast a stigma upon its victim. The social background of the disease was little understood and the public thought that people suffering from consumption were somehow blameworthy. Our reactions toward syphilis have been even more pronounced because not only is the acquirement of this disease a great human tragedy but the method of contracting it is frequently associated with conduct which is surrounded with inhibitions, prejudices, and often with social stigma. The fact that syphilis is often associated with prostitution or other forms of promiscuity, led to a feeling on the part of the public that the acquirement of this disease constituted just wages for sin. Many of the laws and much of the public health policy in the past have over-emphasized the association of syphilis with prostitution.

It is only in recent years, since it became clear that so often syphilis is acquired in socially sanctional family contacts or through accident, that the emphasis on prostitution as a factor has somewhat diminished. The fact that all cases of congenital syphilis and at least half of the cases of extragenital infections are or should be devoid of social stigma, makes it clear we have erred in the past in believing that the solution of the problems of syphilis lay exclusively in the control of prostitution. Furthermore, a large proportion of those who acquire syphilis as a result of promiscuity do so in the ignorance and exuberance of youth. In such cases it is the conduct and not the disease itself which is the proper object of social condemnation.

It is now believed by leaders in the field of public health and of medicine that we are on sound scientific ground in viewing syphilis as a highly prevalent, communicable disease affecting the righteous as well as the wicked, the rich as well as the poor, the wise as well as the stupid, and all races and conditions of men, women, and children. We will make progress more rapidly by dealing with syphilis in accordance with the well established principles of control of communicable disease and in making as few exceptions as possible in favor of or against syphilis. If, when confronted with a problem in the control of syphilis we consider what we would do in a similar case involving tuberculosis, we will usually be on a sound policy basis. For both are familial diseases, both are chronic with long periods of infectivity, both have a complex social background which must be taken into consideration. Syphilis, however, unlike tuberculosis is quickly controllable, curable in its early stages and can in all but its final periods be treated as an ambulatory disease. In fact, we can treat five cases of syphilis for what it costs to treat one case of tuberculosis. The advantages are therefore very greatly on the side of syphilis as compared with tuberculosis, and no less impressive a body than the New York State Health Commission stated that its conquest is within our power.

Let us, then, consider the problem coldly and scientifically. All circumstances point to our ability to control syphilis far better than we have tuberculosis, to stamp it out more effectively than we have typhoid. There is no intermediary host such as we find in mosquito-borne malaria or louse-borne typhus, and there is no reservoir of infection aside from man himself. And we know how to render such cases noninfectious.

The first sign of syphilis is a sore or lesion

at point of contact with the infection. It appears from twelve to forty days after exposure. It may not be painful and may run a slow course, sometimes three to eight weeks. This is called the sero-negative stage, for the blood is not yet positive in its reaction to the famed Wassermann test for active syphilis. The diagnosis can be made readily, however, in any good laboratory by the darkfield test, which shows the causative organism under the microscope. If adequate treatment is begun in this primary stage, the disease can be cured in 86 per cent of all cases. If treatment is delayed only a few days or weeks until the blood Wassermann becomes positive, the cures drop from 86 to 64 per cent.

The second stage is often characterized by skin eruptions, which may look like measles, a food rash, or a light case of chickenpox. The rash may or may not be accompanied by falling hair, fever, sores in the mouth, headache, indigestion. However, in one man out of every five, and one woman out of every three, all early symptoms are so evanescent as to be recognized. Yet the blood Wassermann is positive and if the test was used routinely by all physicians in all physical examinations it would uncover many unsuspected cases.

In practically every case, sooner or later the disease becomes latent and burrows within like a termite. There are no symptoms other than the positive Wassermann, and the best of treatment produces a satisfactory result in less than half the cases.

Then, there is the third stage. Perhaps there is nothing suspected until a syphilitic baby is born; perhaps when life insurance is refused because of organic heart disease. Perhaps the stumbling gait of locomotor ataxia, the irritability and delusions of general paresis, or failure of vision preceding total blindness, first brings knowledge of the mad-dog infection which has, at least, a strangle hold and which may turn its victim into a white faced invalid with damaged heart and blood vessels, a derelict whose face is eaten by great sores, or a homicidal maniac behind barred windows.

What can be done for such cases is largely by way of alleviation; though 25 to 30 per cent complete remissions can be effected even among paretics. But from the public health point of view it is not necessary to effect a cure in each individual suffering from syphilis. Our hope of control lies in breaking the chain of infection at its weakest link—the early case.

Fortunately, diagnosis of the disease is easily made as soon as it becomes infectious; and by treatment we can end infectiousness promptly, thus preventing spread of the disease from one sufferer to others. It is our very definite responsibility, therefore, to reach each case promptly and to treat all syphilitic pregnant women, for we can absolutely prevent transmission of the disease from mother to child.

Yet in spite of these facts which, theoretically, make even the eradication of syphilis possible, the syphilis rate in this country is not declining. Sweden, Norway and Denmark, with a population approximately equal to New York State, have less than 1600 cases of syphilis each year. In April of last year there were 21,984 cases under treatment in upstate New York alone, excluding New York City. In that area, 1,836 new cases were diagnosed in one month. In Sweden, with almost exactly the same population only 431 cases occurred during the entire year previous.

Citizens of Florida, the land of sunshine, of flowers and of good health, let us see how this scourge is affecting us at home! As previously stated, syphilis has no respect for classes, conditions, communities or races. Syphilis is not foreign to us nor are we exempt. It is in our midst; let me state the menace is very much in our midst. From a report of blood tests for syphilis just received from the Florida State Board of Health for the first nine months of 1936, the following astounding figures were disclosed. Out of a total number of 105,036 blood tests made 11,686 were positive for syphilis, 5,182 partially positive and 5,215 unsatisfactory for examination. Just think of it, People of Florida, approximately 17,000 cases of syphilis from 105,036 tests made for nine months of this year in our dear state while in the combined countries of Sweden, Norway and Denmark there are less than 1600 cases of syphilis each year and in Sweden there occurred only 431 cases during the entire previous year.

The things for us to do are closely outlined by Dr. Thomas Parran, Surgeon General,

United States Public Health Service, namely:

1. Find syphilis. The obscure cases will never be found in time except by the Wassermann dragnet.
2. Treat syphilis promptly. A few days delay may mean failure of treatment.
3. Examine for syphilis the family and all other contacts of the syphilis patient.
4. Prevent the birth of syphilitic babies by requiring blood tests before marriage and early in each pregnancy.
5. Teach syphilis and talk syphilis. The facts about it must be known to all the people.

The methods may be worked out to fit our need. Syphilis control is today's joy. Our children will hold us criminally careless and incompetent if, with the means at hand, we fail to end this scourge within our generation. This is one contribution we know how to make toward a safer, happier world for them to live in. Syphilis must be the next great plague to go. With the combined efforts of physicians, public health officials, educators, and the public, syphilis can be conquered. We must attack it now.

HEART PAIN*

E. W. Bitzer, M. D.,
Tampa.

Most individuals who reach middle life have at times felt pains in the chest in the region of the heart. Often these pains are of short duration and are frequently attributed to gas in the stomach. The spectre of sudden death is so intimately associated with heart disease, however, that any pain in this region may lead to a state of nervous apprehension. Before discussing heart pain I am going to tell you something about the pains in the heart region that do not originate in the heart itself.

A few years ago I had occasion to investigate this subject and in going over 4,052 case reports I found that 561 patients had chest pains in the heart region who did not have heart disease. This will give you some idea of how common such pains are. As to the cause of this pain it was found that the largest number of these patients had rheumatism, chiefly involving the spine and intercostal nerves. It was found also that in a considerable number the pain originated in the gastro-intestinal tract, either in the stomach or in the intestines; for instance, too much acid in the stomach was a common cause, as well as constipation and allied troubles in the colon. Pleurisy was also found to be a frequent cause of the pain about the heart. The type of pleurisy which is likely to be confused with heart disease is that which is localized and near the heart, producing pain which may easily be taken for heart pain. In 48 cases no physical cause for the pain was found and it was assumed that it originated in a functional disturbance of the nervous system. In other words it is possible to have pain in the heart region that is purely nervous in origin.

There are certain conditions which occur in the heart itself that are not dependent upon pathological changes or organic heart disease, yet which may at times be responsible for pain in this region. For instance, many people have premature beats: that is, two beats which occur close together, followed by a long pause and then an unusually hard beat. This is caused by a disturbance of the nerve mechanism that controls the heart beat and although it causes a peculiar sensation in the chest and at times a feeling of pain, it is in itself a harmless condition.

A somewhat similar disturbance, due to an imbalance in the nerve control, is commonly called a "nervous heart." In such individuals the heart beats too fast and even on slight exertion the heart rate will be 130 or 140, where the normal is 80. Nearly all of these individuals complain of pain in the left chest in the region of the heart. Usually they do not have any organic heart disease. The exact origin of this trouble is unknown but it frequently occurs in individuals who have glandular disturbances and sometimes follows acute infections of various types.

The location of the pain in this group, which may be designated as the extra cardiac group, is usually in the left breast or

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just under the left breast. Sometimes the pain is sharp and darting; at other times it is more of an aching. In some of these cases the pain runs down the left arm, just as it does in angina pectoris. Generally, with but few exceptions, the pain is not brought on by exercise or by excitement as it is in angina pectoris. Indeed, at times it may be relieved by exercise.

A very unfortunate condition sometimes occurs in these individuals: they become heart conscious. They feel every heart beat. This, of course, keeps them in a state of anxiety, has a tendency to increase the sensitivity of the nervous system and to aggravate their symptoms.

The most common pain that actually occurs as a result of organic heart disease is called angina pectoris. This is a disease of middle or old age. The cause of this condition is usually arteriosclerosis, or hardening of the arteries. All people past middle life have hardening of the arteries, but in the majority it is either not well marked or does not involve the arteries that supply the heart muscle with blood, the coronary arteries. When the coronary arteries are involved in this process they are narrowed and obstructed to a point where the heart muscle receives an insufficient amount of blood, which reduces the capacity of the heart for work. As an illustration, when the arteries that supply the legs are obstructed to a considerable degree, you might possibly walk one block without trouble, but if you walked two blocks you would begin to get a pain in your legs. If you stop and stand still for a few minutes the pain will disappear. That pain would be produced by an insufficient blood supply to the muscles in the legs. The same thing happens in the heart. Individuals of this type can walk one block without any discomfort but if they walk two blocks they begin to feel pain in the chest. This pain usually occurs in the middle of the chest, behind the breast bone and the type of pain is gripping, often described as though one were being squeezed in a vise. Frequently this pain is accompanied by pain in the left arm, a state of apprehension and a feeling of impending dissolution. Curiously enough, not all individuals who have hardening of the arteries in the heart have this pain, which is known as angina pectoris. some of them merely have a reduced capacity for work; they get tired easily and are short of breath; also there are certain cases in which exercise does not cause the attacks. These individuals usually have their attacks at night, which is probably explained by the fact that the blood pressure goes down during the night, consequently reducing the circulation in the heart muscle through arteries that are partially obstructed.

Angina pectoris patients do not necessarily die immediately. A considerable number live ten years or more, provided they live carefully. Occasionally the pain disappears for a considerable period of time and such patients are inclined to feel that they are cured; nevertheless the capacity of the heart for work is materially reduced.

A condition that is closely related to this is called coronary thrombosis. In coronary thrombosis there is a sudden complete occlusion or stoppage of a branch of the artery that supplies the heart muscle with blood. Such a condition can occur only in blood vessels that are already diseased and consequently is common in angina pectoris cases. This is followed by the death of a section of the heart muscle. The muscle tissue so affected is absorbed and gradually replaced by scar tissue. With this there is usually very severe pain which requires large doses of morphine to relieve it. Extensive lesions of this type are sometimes followed by rupture of the heart, resulting in sudden death. Even in these cases of sudden occlusion, pain is not always present and shortness of breath may be the only symptom. The ability to recognize this condition and a knowledge of the necessary treatment has undoubtedly reduced sudden and unexpected deaths to a very marked degree.

We have just discussed the relationship of angina pectoris and coronary thrombosis to the ordinary type of hardening of the arteries, in which the blood pressure is usually found to be normal. High blood pressure, which causes a hardening of the smaller arteries, may be a factor in the

production of angina pectoris. This is proved by the fact that most women who develop angina pectoris have high blood pressure. It is rather common, however, for people with high blood pressure to have pain in the region of the left breast, which is not angina pectoris but is a pain similar to that which occurs when the heart beats too rapidly. We frequently call it fatigue pain.

It has been proved by animal experimentation that an elevated blood pressure will cause an enlargement of the heart in about two weeks. It is possible for high blood pressure patients to develop heart disease without pain; in fact it is possible for them to die as a result of heart disease without any apparent disease of the blood vessels in the heart. Such individuals usually develop shortness of breath and swelling of the legs as a sign of heart failure.

Pain in the chest is sometimes found in syphilitic cases where the disease has attacked the aorta and heart itself. In some of these the wall of the big vessel, the aorta, gives way and a sac is formed on the side. This is called an aneurysm. The majority of such individuals have pain in the chest, which is more continuous, therefore differs from that of angina pectoris. Syphilis may cause an inflammation, however, which stops up the openings of the coronary arteries where they branch off from the aorta. This may produce typical angina pectoris. Curiously enough a certain number of such cases with complete occlusion of both arteries that supply the heart muscle do not have pain.

There probably are many other factors concerned in the precipitation of angina pectoris. Various acute infections play some part not only as a cause of arteriosclerosis but may be the starting point of the attacks of pain. For instance, it is known that rheumatic fever, which is often called acute inflammatory rheumatism, and typhoid fever attack the arteries and may be factors in the production of arteriosclerosis. It is common in the history of cardiac cases for the onset of symptoms to occur after a cold. For this reason we always consider colds a hazard and feel that they may play a part in the production of heart disease.

In conclusion, I wish to emphasize the difficulty in determining whether a pain in the chest originates from a diseased heart or from some other cause. It is extremely important to determine as accurately as possible the origin of the pain. If an individual knows he has a diseased heart he is in a position to prolong his life by careful living. Most of the individuals who die suddenly and unexpectedly are those who attributed their symptoms to indigestion or some cause other than heart disease and consequently more or less ignored their existence. In contrast to this are the many individuals with serious heart disease who live in comfort for a good many years, largely through an intelligent understanding of their condition.

HOLIDAY HAZARDS*

W. Wardlaw Jones, M. D.
Dade City.

The season of the year that should be the most joyous only too often becomes one of heartaches and of sorrows. In a great number of instances these troubles might have been avoided.

Let us consider some of the apparent causes and attempt to arrive at a means of avoiding these hazards, so that this joyous Yuletide season may be one of happiness and pleasure in all family circles.

The one hazard that your newspaper will be quick to make headlines of, because 'tis excitement, is that great tragedy, the automobile accident. In reading the accounts of accidents in our newspapers one may generally see that the accident could have been avoided if some one had used a little precaution or had been considerate of the other fellow.

A few of the outstanding causes of accidents will be mentioned. Undue hurry. Speed seems to be one of the main objects of the car manufacturers today; and it, no doubt, enters to a great degree in the production of our highway accidents. In a vast majority of wrecks, we may, upon in-

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vestigation, find that either one or both cars involved was speeding at the time of the accident. It is a physical impossibility for a car to be handled as easily at sixty to seventy miles an hour as it is at forty to forty-five miles an hour. I am not an advocate of extremely slow driving but I am an advocate of safe driving. Do not exceed that speed which is consistent with safety on a given piece of road, whether that highway is filled with cars, totally empty, rough, smooth, curved or otherwise.

Neglect of giving proper signals as to your intentions of turning may cause an accident. Generally speaking, this type of accident will cause disability instead of a mortality for the vehicles involved are usually traveling at a relatively low rate of speed.

Just plain inattention to what you are doing and where you are going is a cause of some accidents. Closely allied with this cause is that of driving with the radio going and thus, gradually, the thoughts become absorbed in the program to the sad neglect of one's driving duties. Excessive fatigue also is in this same class. As the holiday season approaches there will be a number of people on our highways who will be going rapidly towards their homes, only to discover that from pure and simple exhaustion they are unable to drive properly. This is exceedingly dangerous. Failure to exhibit the fundamentals of courtesy comes in for its share of trouble also.

An unavoidable and yet partially avoidable cause of accidents on the highways is mechanically unsound cars. This does not cause nearly so many accidents as the general public sometimes thinks it does. The real reason for this low figure is very obvious for these older cars are traveling much slower than the average speed of the road.

First among the definitely avoidable causes of accidents I will mention that infernal, potential death stalker of our highways, "Florida's Sacred Cow." This situation of cows on our highways is giving our good state a black eye and thus unfavorable comment among travelers. It is true that a few other states allow them on their highways, but that is no reason why our state should be in the backward class and still let them remain there as a menace.

In our own United States during 1935 there were thirty-seven thousand people who entered the highway alive, but who received instant death or death due directly to an accident that took place on that highway. Just this past week the Associated Press carried a news item to the effect that at the present rate the highway mortality would reach the all-time record of thirty-seven thousand five hundred for this year. Certainly that is a ruthless sacrifice of human life. Death is but a small part of the loss. Many more are injured than are killed, and too many of these are totally and permanently disabled. Then come the costs of medical care, hospitals, and the financial losses from being unable to work. Aside from the monetary losses we must take into account the mental anxiety, the worry, the sleepless nights and days that the family, not the patient, must have thrust upon it. You and I can name several of our outstanding, most beloved citizens, whose lives were snuffed out right in the prime of their careers. Their family's loss was great, but society's loss was greater.

The next one of the hazards is one too frequently associated with the automobile accident and that is the use of spirits. We too often can find that the use of spirits was in all probability the major contributing factor to the accident. If it is impossible for one to remain sober enough to drive carefully then he should stay off the public road and thereby not be a menace to the entire army of the traveling public.

This is also the season of the year when may people will be celebrating the occasion of Christmas by the use of fireworks. In careful hands these things are all right, just as firearms and ammunition are. But many slips are made and many accidents will occur. Children are often the sufferers since they play with the firecrackers and cap pistols more than adults do. Instruct your child in the proper use of these dangerous things and it will pay you great dividends.

Gunpowder will not only cause a skin burn, but the explosion of it will tear away skin, muscles, bone and all and thus leave a permanent deformity. When a burn or in-

jury of such a kind does occur, treat it conservatively, call your family physician at once. He will then tell you what is the best thing to do for that particular burn for the treatments will vary with the damage done. One of the most complicating factors always in burns is infection. This frequently is mild and gives no real trouble, but it may be one of the serious kinds, such as erysipelas, true blood poisoning, or tetanus. Any one of these is a serious complication. The alert physician will always advise in cases of powder burns that tetanus antitoxin be given to the patient unless there is some real reason why that particular person should not receive it. The germ which causes this dreaded disease is known as the tetanus bacillus. Its spores are extremely resistant to everything. Even the heat of the manufacturing process frequently fails as does the heat and force of the explosion of the gunpowder fail to destroy them. This antitetanic serum is given into the body of the accident victim to help protect him from the effects of tetanus bacilli should they also enter. The same thing can be said about puncture wounds, compound fractures and the like, for tetanus also is a severe complication in them.

Many millions of people will sit down to a veritable feast during this month, and will eat a great deal more than is good for them to eat. When you or I do that thing we are doing nothing but making our body take care of more than it is normally able to take care of. The net result will be that the intestinal tract will rebel against it, or the tract will go ahead and complete its task of digestion and the general body systems will then be called upon to dispose of the excess. Right now our type of foods differs somewhat from that taken in midsummer. We are now indulging in the concentrated and rich foods, such as fruit cakes, pastries of all kinds, meats and the rich dressings, sweets and many others. Many of our cases of so-called food poisonings are the result only of our over-indulgence in eats. Much nausea and vomiting and even diarrhea will follow. A really bad case of illness can be brought on by our inability to say "no" at the correct time. No piece of machinery, and our human body is a highly specialized machine, can work efficiently when it is overloaded.

Just what harm can be done by things of that sort might be asked? They are more numerous than you would expect. The intestinal tract is overworked and must take a certain time off for rest. What happens then? There will be an accumulation in that tract of things that should be expelled and are not. Putrefaction takes place, we absorb these noxious products, and will become more and more toxic and constipated before we are aware that anything much is wrong. Then, while the body is at that low ebb, will be an excellent time for a bad cold to begin, a pneumonia to start, or any other infection, for that matter; and it will always be a severe one, too, for we will be unable to properly combat it.

In just a few words let me sum up some of the more important points mentioned in this short talk. Let us make it a happy time for all. Be considerate and courteous and careful in driving, and thus avoid an accident. This is mostly to protect the other fellow. Care in the use of firearms and fireworks should be our watchword. That is to protect the other fellow and also ourselves. Now for the last item which concerns only the individual. Be conservative with your eating; do not overeat for it will be at your own expense if you do that thing. Remember these few simple words and enoy a MERRY CHRISTMAS and a HAPPIER NEW YEAR.

IMMUNIZATION*

S. C. Harvard, M. D.,
Brooksville.

Medicine is divided into two branches; the prevention of disease and the cure of disease. This evening I would like to talk to you for a few minutes on one phase of prevention of disease; namely, immunization.

By immunization is meant roughly the body's resistance to disease. This may be either natural or acquired. When we speak

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of an individual having a natural immunity to a disease we mean that that individual has the resistance to the disease within his own body without having had the disease previously or having had any vaccinations or innoculations against the disease.

Acquired immunity may be divided into active and passive.

Passive acquired immunity is that immunity which is brought about by the introduction into the body of a solution of antibodies already manufactured to protect a person from a particular disease. An example of this is the use of serum from a person who has had measles to protect a child from having measles who has been exposed. Another example is the injection of a solution of antibodies in the form of antitoxin such as diphtheria antitoxin when a person has been exposed to diphtheria. Usually an infant up to six months of age has a passive immunity to contagious diseases acquired from the mother.

One form of active acquired immunity to a disease may be brought about by having the disease in question. We are all familiar with the fact that in certain diseases such as typhoid fever that an attack usually brings about an immunity from this disease for the rest of the person's life. The reason why a person is immune to a further attack of the disease is thought to be due to the fact that in overcoming this disease the body has manufactured certain defensive agents known as antibodies. These antibodies act only in defending the individual from that particular disease from which he has recovered and usually remain in the body in sufficient quantities to protect the individual from that disease for life.

Another form of active acquired immunity which is also called artificial immunity is that brought about by vaccinations and innoculations. Immunization in this case is brought about by introducing into the body certain agents which will cause the patient to manufacture sufficient antibodies to protect him against the disease. This protection usually lasts a varying length of time according to the ability of the patient to manufacture antibodies and the disease against which these antibodies are manufactured. Unfortunately, we cannot provide an immunity for all diseases.

Artificial immunity probably had its beginning with Edward Jenner in 1796. It was in that year that he announced his vaccination against smallpox. For almost a hundred years then until 1885 when Pasteur developed his method of immunization against rabies very little was done along the line of artificial immunization. Since 1885 a great deal of work has been done along this line. We are now able to prevent such dread diseases as diphtheria and typhoid fever. Recently there has been quite a bit of work done on scarlet fever, whooping cough, bacillary dysentery and measles. This work has been very encouraging and we have every reason to expect definite control of these diseases in a short while.

Doubtless we are all familiar with the ravages that smallpox made on the human race during the "Dark Ages." Because of Jenner's work this disease has become a rarity. However, it is not extinct and every now and then we read of an outbreak in certain communities. During the past three years there have been eighteen cases of smallpox reported in the State of Florida but fortunately no deaths. If we become careless in not protecting ourselves and children from this disease it will again flourish as it did in the eighteenth century. Vaccination against smallpox is a rather simple procedure and preferably should be done during infancy around the age of three to four months. At this age the reaction is slight and usually the vaccination "takes" very well.

Around the turn of the century a good bit of work was being done on immunization against diphtheria. This, like a good many other procedures in immunization, was not perfect to begin with, but has gradually been developed to such an extent that we can now promise an immunity to this disease for life. At first we could only offer passive immunity by means of injection of diphtheria antitoxin. This immunity lasted only for a short time—two to three weeks —after which time the individual was just as likely to develop the disease as before. Next toxin-antitoxin was developed which was given in three doses at weekly intervals and which usually gave adequate immunity in about 75 per cent of the cases. In recent

years a diphtheria toxoid has been developed which will give an adequate immunity in 90 to 95 per cent of the cases. This toxoid may be given in one or two doses and usually requires two to six months for an immunity to develop. You may wonder how we are able to definitely find out how an individual has an adequate immunity to diphtheria. This is ascertained by means of the Schick test. This test is done by injecting a very small amount of diphtheria toxin into the skin. If the person injected is susceptible a definite reaction will occur showing that this individual does not have sufficient antibodies to protect him from diphtheria. In other words we can definitely determine by means of the Schick test whether an individual is susceptible to diphtheria, and, in case he should be, we can definitely develop an immunity. By checking this individual with the Schick test we can be sure that this immunity has been developed. Most authorities agree that immunity to diphtheria can best be developed by means of the diphtheria toxoid. The ideal time to develop this immunity is at the age of six months. The appalling fact is that here we have a disease for which we have a test to determine susceptibility and a definite agent to produce immunity and yet in the State of Florida there were reported 1,369 cases of diphtheria in the past three years with 198 deaths. By giving diphtheria toxoid when the infant is six months old, as it is losing its passive immunity acquired from the mother, there should be no reason why diphtheria should not be stamped out altogether. This can never be done by the doctors alone but rather by the intelligent cooperation of the parents and the doctors.

Typhoid fever within the past 25 years has become more and more rare. However, during the past three years there were reported 481 cases of typhoid in Florida with 167 deaths. This is a disease which has in the past claimed many lives but there is no reason why it should not be eventually stamped out also. Most authorities agree that immunity against typhoid should be begun early in life, around two years of age, as it is not only more necessary then than later but it causes the child less discomfort than when done for the first time later in life. Unfortunately this immunization does not protect one for life and should be repeated every three years.

Recently there has been some very good work done on immunization against whooping cough by means of whooping cough vaccine after the method of Sauer. This is still somewhat in the experimental stage and cannot be relied upon absolutely but we feel that it is of some value and should be given about the age of eight months.

Vaccines have also been made for rabies, cholera and Rocky Mountain spotted fever which have been proved to develop a definite immunity to these diseases. At present a great deal of work is being done on vaccines for pneumonia, meningitis and poliomyelitis or infantile paralysis.

It is well to call to your attention tetanus and gas gangrene antitoxin. Like rabies it is not practical to immunize an individual against these infections unless the individual has received some injury which might develop into one of these diseases. Such injuries as puncture wounds, gun shot wounds, compound fractures, powder wounds and contaminated wounds should certainly be given prophylactic doses of tetanus antitoxin and in some instances gas gangrene antitoxin.

I have tried to outline in the time allotted to me the important factors in immunization. Your State Board of Health is doing a wonderful work in immunizing against typhoid fever, diphtheria and smallpox, children of school age but the important thing is that they cannot get to the child in most instances until he is six or seven years of age. That means that there is at least about five years lapsing between the time the child loses its passive immunity acquired from the mother and the earliest possible opportunity for the health authorities to immunize the child against these diseases. During this five years we have no way of being sure that the child will not develop any of these diseases if exposed. Remember, about 75 per cent of diphtheria cases reported are in children between the ages of two and six years. It is true that some children have a natural immunity to some diseases, but we have no

assurance in any case. Immunization of the child in infancy and early childhood is a very good form of health insurance. From an economic standpoint, usually the child can be immunized from all these diseases at a lower cost than for which any one of them can be treated. This is a minor consideration, however, and the one thought which I would like to leave with you is that you are exposing your child to disease with its resulting ill effects, and in certain instances to death, all of which could be prevented by consulting your family physician or county health officers, and having your child properly immunized against these diseases.

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THE X-RAY IN EARLY DIAGNOSIS*

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Ocala.

Medicine is a constantly growing, progressive science that is built with meticulous care and careful consideration upon established facts, to be used for the preservation of health, the alleviation of suffering and the cure of disease. Progress in medicine is fostered by investigation and research, but the cornerstone upon which the practice of good medicine rests is correct diagnosis.

During the past four decades clinical diagnosis has steadily improved in accuracy, due in part to a wider, general knowledge of disease, but more particularly through the various laboratory procedures and special methods of examination.

The discovery of the roentgen ray in 1895 made available a diagnostic procedure of rare precision and, although being among the youngest of the medical specialties, roentgenology has made rapid progress in diagnosis and treatment of disease. New methods have appeared, such as the study of the gall bladder, the kidney, the uterus, the spinal canal, the lungs and gastro-intestinal tract, by the use of opaque media which casts shadows of the various organs or regions on the fluoroscopic screen and on the sensative x-ray film. Present-day diagnosis and treatment of diseases of the brain is made possible by radiograms after the introduction of air into the cavities of the brain.

The value of an x-ray diagnosis depends on the skill and training of the roentgenologist, and it perhaps is not necessary to say that he must not only have a thorough medical education, but special training in his particular field. He is, therefore, a medical consultant and, as such, assists the surgeon, the general practitioner and other specialists in diagnosing and treating disease.

Today radiographs can depict practically every part of the human body. They give accurate information concerning the bones, the different tracts, the body cavities, the individual organs and the soft tissues. They give an exact picture of the normal and the abnormal. Suspected disease is confirmed or ruled out. Diseased organs or tissues may be discovered long before they have a chance to produce noticeable signs or symptoms. When discovered in the incipient or early stages many diseases yield readily to treatment; if detected late irreparable damage may have been done—a cure may be impossible. How often do we see people crippled and deformed, due to fractures that were not detected at the time of accident or were not properly treated? How often in x-ray examinations do we see cancerous growths that are not discovered until the case is utterly hopeless.

The first general use of the x-ray was in examination of bones and it is still considered indispensable in diagnosis of fractures and bone disease. X-ray films in several planes show accurately the type of

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fracture, the position of the broken parts and enable the physician to properly reduce the fracture. In crushing injuries to the extremities, an x-ray examination may be the deciding factor as to the advisability of conservative treatment or amputation. In this day of increasing automobile and industrial accidents, the x-ray film or fluoroscope determines accurately and timely the extent of damage done. In such examination, skull injuries of grave significance may be detected at a time when treatment is urgent. Fractures of the spinal column are clearly visualized; dangerous displacements are detected and replaced under x-ray guidance.

Not only are we concerned with the prompt discovery and treatment of bone deformities due to accident, but to those due to congenital and developmental defects. It is only in the past generation or so that much could be done for the cripple. The well-known "hunch-back" deformity is preventable today if discovered early enough; club feet are easily corrected in early life.

The medical profession lays much stress upon the early recognition of, and the removal of, focal infections. The discovery of an abscessed tooth on a dental x-ray film may prevent such complications as rheumatism, arthritis, heart and kidney disease. The early diagnosis and treatment of infected sinuses may prevent attacks of hay fever, asthma, bronchitis, bronchiectasis or other respiratory diseases. By periodic health examinations, using as indicated, laboratory tests and x-ray studies, we emphasize prevention of disease or early correction.

There is no disease in which early diagnosis is more important than in tuberculosis. Through a crusade by public health authorities, cooperation by the public, improved diagnostic methods, and more efficient treatment, this disease has been displaced from the second to the sixth place in the mortality rate. The childhood type of tuberculosis, in which the lymph glands of the chest are affected, depends on the x-ray for positive diagnosis. Postmortem examinations show that a large percentage of the population is affected at least mildly before the age of six. Any child with symptoms suspicious of chest tuberculosis should not be denied an x-ray examination. In adult pulmonary tuberculosis, the disease may be discovered by x-ray examination before clinical signs are definite, or before the laboratory tests are positive. This detection of early tuberculosis has saved many lives as in this stage the disease is very limited and usually responds to treatment. Under x-ray guidance, treatment of more advanced tuberculosis by lung collapse (induced by injecting air into the pleural space or the surgical removal of ribs) is now arresting or curing many cases that were a few years ago hopeless. Periodic x-ray examination is a necessary routine from the inception of tuberculosis until cured.

X-ray examinations are valuable diagnostic aids in pregnancy. Such graphic information decides before labor begins whether a normal or abnormal delivery is expected. No method of examination is comparable to the x-ray film in detecting abnormalities in the unborn, in determining the size of the fetal head, in measuring the diameters of the maternal pelvis. It is a well known fact that external measurements are only approximately accurate—measurements on the x-ray film are accurate to within one or two millimeters. Not only does x-ray examination of the expectant mother give an accurate reconnoitering of the condition of the pelvis, but it shows fetal position, determines whether single or multiple, dead or alive. The obstetrician from such valuable data anticipates the type of delivery as normal, instrumental or cesarean—it is time-saving and often life-saving.

The greatest task that confronts the medical profession today is the control of cancer. It is definitely on the increase and is the cause of more deaths annually than any other malady except heart disease. Its early discovery, when the growth is entirely local, offers the best chance of cure. At this time before the cells have scattered to distant tissues or organs, many cures are effected by surgery, x-ray and radium. Early diagnosis necessitates keen appreciation of the patient's history, a complete physical examination and appropriate spe-

cial examinations. Only about 20% of stomach cancers can be effectively treated at the time diagnosis is made—the majority are so far advanced that cure is impossible and any treatment given is for palliation only. The responsibility for eradication of malignant disease rests largely with the general practitioner and the public itself. The early signs and symptoms of cancer often resemble those produced by conditions of no serious import and hence are often disregarded. Only the patient is aware of the symptoms and only he can bring them to the attention of the physician. Any patient suffering from chronic stomach trouble should have a thorough x-ray examination which, with other tests will indicate the nature of the trouble. It is a noticeable fact that through the medium of the x-ray, as a diagnostic procedure, many lesions of the digestive tract—such as ulcers, diverticula, tuberculosis and cancer are being discovered earlier and at a time that treatment may be effectively administered.

The diagnosis of bone tumors is in most cases made by means of the x-ray, which will also aid in determining the type. If the lesion is benign, appropriate treatment is begun; if of dangerous type, such as sarcoma, early amputation of an extremity is usually the only chance of a cure. However, certain types of these tumors also yield to treatment by x-ray and radium. An accurate diagnosis therefore is very important as, otherwise, a leg or arm might be needlessly sacrificed when less radical treatment might suffice. These bone cancers remain local in character for only a short period; cancer cells are soon scattered to the lungs and other regions. At this stage of the disease few cases are benefited. There is, therefore, only one rational approach to the fight against dangerous tumor growths—early discovery and early treatment administered by competent physicians.

Before the use of x-ray and the cystoscope in the examination of the urinary tract, many patients suffered and even died. Kidneys were destroyed by large stones; other parts of the tract were obstructed by strictures, kinks and adhesions; tuberculosis was discovered only in the late stages; unseen cancerous growths did their deadly work. But today, due to better methods of examination, all such conditions can be discovered and treated early enough to often cure, or if not cure, most certainly prolong life.

The correct and accurate diagnosis of disease is the greatest concern of the physician, and the value of x-ray as an aid and important factor in diagnosis is unquestioned.

PRENATAL CARE*

CHESTER F. AHMANN, M. D.,
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Motherhood is the crowning glory of womanhood and generally is assumed to be the normal outcome of the marital state. The tenderest maternal care always should be conserved; but it must be borne in mind that the woman in modern society does not necessarily come to her task of motherhood fully equipped with knowledge and skill to raise her baby successfully. Maternal instinct and traditional ways of bringing up babies do not necessarily guarantee safety. In primitive society, where one thinks of the baby as born and brought up with few frills, the early infant mortality was high and the average life of mothers who bore many children all too brief. Modern methods of public health have lengthened the lifetime both of mothers and of babies. A scientific study of the rise and fall of populations indicates that the prevailing attitude toward women and children usually determines national destiny.

It always has been difficult to rear successfully the coming generation. Nature at its source is prolific even in mankind but the difficulties and dangers leading to maternal and early infant mortality and morbidity are usually great.

Most men as well as women assume that childbirth will take care of itself as long as a good doctor is present at the time the baby is born. But, unfortunately, this is not the case. It is increasingly impor-

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tant for both husband and wife to know that prenatal care may be the means of preventing developments of a serious nature. A woman tends to think too little of the risk.

Why is it child bearing so often ends tragically? Is it the fault of the medical profession? In a large majority of cases, no! The fault lies at the door of the general public and particularly of the women. Hospital records show that 75 per cent of the obstetric tragedies occurred to women who had no medical attention previous to the onset of labor. The medical profession has stressed the importance of prenatal care. Warnings have been delivered by magazines, by newspapers and by radio.

What is prenatal care? Prenatal care is the medical guidance of a pregnant woman throughout pregnancy. It must be sufficiently intelligent, conscientious and frequent to detect and control conditions which might otherwise result in harm or death to the prospective mother.

Who should receive prenatal care? All expectant mothers whether in their first or subsequent pregnancies should have this care. The physician aims to correct any physical defects, to institute proper diet that will insure a healthy baby and to save the wear and tear on the physical well-being of the mother.

How many actually benefit by prenatal care? All those who receive this care as it should be given will benefit in the following ways:

They are relieved of all anxiety. The importance of this aspect of prenatal care cannot be over-emphasized. It should mean much to the peace of mind of the prospective young mother whose ears are filled with tales of disaster, brought to her by well meaning but stupid friends. And it should mean just as much to the solicitous but helpless husband.

Adequate prenatal care helps to keep well women well. Fortunately this group includes most pregnant women. Such ailments as they have are insignificant. They may or may not require treatment, but the decision should be made by the physician in charge. A headache, even a persistent headache may mean merely constipation, or it may be a simple migraine, or it may be the forerunner of convulsions. This is for the doctor to decide.

Most important of all, adequate prenatal care will sift out those women in whom complications are developing or who are stumbling blindly into a stormy or impossible labor. This is the group the doctor must reach. These are the women for whom the doctor can do so much if they will but let him. Complications can develop or exist in the woman who is seemingly in good health! Therefore all pregnant women should have adequate attention.

What are the details of adequate prenatal care? A physical examination is essential. At the first examination the existence of a normal pregnancy is determined. The measurements of the pelvis are important. In general, they indicate whether the pelvis is normal or whether it is deformed. Such knowledge in advance of labor sometimes means the difference between a live baby and a dead baby and the difference between a mother restored to good health and a mother partially disabled. The condition of the heart, the blood pressure, the kidneys, the urine and the thyroid gland should be determined. The patient's weight should be registered; the average gain throughout pregnancy is a total of one-fifth of the body weight.

Typical instructions for the pregnant woman are contained in the following list of general rules:

Visits: It is essential to go to the doctor's office every four weeks the first seven months and once every two weeks thereafter. It is well to make a written list of questions to avoid forgetting any.

Clothing: Wear comfortable clothing and avoid abnormal constriction and high heels. Any clothing which is supported from the waist is undesirable for an expectant mother. The weight of the clothing should hang from the shoulders.

Exercise: During normal pregnancy the woman should be encouraged to take as much outdoor exercise as possible, though in individual cases it is often difficult to specify the exact amount—a safe rule being to desist while still feeling that she could do more without tiring herself. Exercise should consist of walking, driving or motoring over good roads,

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but the ordinary sports should be interdicted, though in the early months sea bathing is beneficial. In the later months avoid long journeys by auto, train or steamer.

Rest: While moderate exercise is important, rest is equally important. The woman should lie down for an hour after the midday meal. Sleep is not essential, but the clothes should be loosened and the mind diverted from its usual channels.

Diet: The welfare of the child as an individual really begins at conception. At that moment, heredity is sealed. From that time on, the developing organism depends completely on the welfare of the mother. A marvelous process, all too little understood by the prospective mother, is being unfolded under conditions which should be made as favorable as possible during the nine eventful months before the "blessed event" takes place. Birth is simply an incident in the larger life process, an incident fraught however with great potentialities for good or ill. To aid this wonderful process of development the expectant mother must regulate her diet. Heredity has much to do with the determination of the looks of a baby, but even heredity may be almost defied by the expectant mother if she regulates her diet so as to insure well formed bones and teeth. The material for the construction of the teeth consists of 85 per cent calcium with a small proportion of phosphorus and other substances. As the teeth are in the process of formation long before the baby is born the mother's blood must supply these minerals. Therefore, for the child as well as for her own needs, the prospective mother should plan her daily diet so that milk, leafy vegetables, whole grain bread and other whole grain cereal foods are included in proper amounts. If food sufficient in quality or quantity is not supplied her own body substances are drawn on to supply these deficiencies. This, of course, can go on only to a certain point. If the mother is not receiving sufficient mineral salts or other food elements the growing baby will draw on her reserves in the bones and teeth and on her store of fat and protein.

It is well known that if iodine in the mother's diet is insufficient the child may be born with a thyroid deficiency. In certain parts of this country the lack of iodine is so great that babies are born cretins, with marked physical deficiencies.

A number of mothers suffer from anemia during pregnancy. The growing babe must have sufficient iron and this must be obtained through the mother. It is highly important then for her to have foods rich in iron. On the other hand, it is a fallacy to believe that the expectant mother should eat for two. Excessive eating may be harmful for both mother and child. A well balanced, wholesome dietary, slightly in excess of her normal requirements is all that is needed to keep the mother in good condition and to provide normal growth and development for the baby.

Dental Care: The expectant mother should see her dentist early in pregnancy. Teeth with cavities should be filled. His advice should be obtained regarding extraction of abscessed or infected teeth. It is essential to see the dentist regularly during pregnancy.

Acute Infections: The acute infectious diseases attacking the prospective mother may seriously affect the unborn child and result in premature birth. This is the case notably of influenza and the pneumonias. The prospective mother, therefore, should be protected in every way against these diseases.

Unusual Symptoms: Report promptly any of the following symptoms: severe or obstinate nausea and vomiting, severe and persistent headache, prolonged constipation, disturbances of vision, swelling of the feet, hands or about the eyes, or spots before the eyes. These are the danger signals and should be recognized and reported at once. No one but the doctor should tell the expectant mother what to do. She should not depend on the advice of her next door neighbor. Many women become unnecessarily frightened by the long list of "don'ts" given by the solicitous neighbors. The doctor is the only one who can be depended on to point out what should be done.

In conclusion let me stress the advisability of every expectant mother seeing her physician early in pregnancy. She should have a complete physical examination, and periodic examinations throughout her pregnancy. She should be impressed as to the importance of correct diet and exercise. The expectant mother should give careful consideration to unusual symptoms — persistent headache, swelling of the feet and about the eyes or spots before the eyes. Every expectant mother, no matter in what station in life, should have prenatal care.

THE RESPONSIBILITY OF THE LAITY TO THE INDIGENT*

J. S. Turberville, M.D.,
Century.

Every community, large or small, has a number of individuals or families classed as indigent. They have not even the bare necessities of life, to say nothing of funds for the proper medical care. Every one who is self sustaining asks the question: "Who is going to take care of these people?" This is answered to a certain extent by the different organizations for charity, that is to say food and clothing are provided. Nothing is said or done about medical care except that some are cared for by the city or county health units. This constitutes only a small portion of those who really need care.

The responsibility of medical care is shouldered directly by the medical man of the community. Every one says: "He is the one to take care of these people." I agree with them, but he needs help in this, and as a general rule this is not forthcoming from laymen. They usually wait to see what will happen. The laity of this country should help provide these things, and should accept it as part of their responsibility. Some may argue that they have given to the different organizations. What of it? The medical man has done this and more. He has given of his time, knowledge, and is usually willing to do more. I heard of an incident that happened in a certain community. A prominent man called the Doctor on the 'phone and said, "Doctor there is a widow with six small children, and she needs an operation; I wonder if you will take care of her for charity's sake." The Doctor's reply was, "I will meet you half way. You pay the hospital bill, and I will gladly give her my services." The man said, "I will call you later." The Doctor is still waiting for the call. Such things happen every day.

I once interviewed a pharmacist who was proprietor of a drug store also. He told me that if I would mark my prescriptions "Indigent" he would gladly give the medicine needed. Every one in the community classed as the laity should look upon these things as the druggist did. Doctors have left their beds in the middle of the night, and made calls several miles away, knowing before they left that they would not receive any remuneration whatsoever. What percentage of the people of this country would do this? A very small number I imagine. Some of them won't even assist by doing a neighborly act. I could go on and on giving incidents that have occurred in all parts of this country, and in the practice of all Doctors, but I will refrain and go into detail further about my original subject, as I am afraid I am only giving our side of it.

If there is any one in a community or town who is in dire need it should be reported immediately and then the public and the Doctor should get together to see what can be done. A scheme can always be worked out by which the needy person may be taken care of without too much hardship on any one concerned. It might be said that the Government of the United States has provided for this, but not adequately. The lazy, shiftless, and indigent are all in one group, as you might say, in one bag. The bag is shaken up and whichever should happen to fall out is the one who gets the help. Until these are separated we will never arrive at a definite plan of government aid. It has been tried and won't work. This problem is the motherless infant of all the people of this country, and not just that of the medical profession.

In the cities and larger towns of the country there are numerous clinics, and receiving wards maintained by the state or city governments, by medical schools, and charity organizations. The situation in these cities is not so deplorable as it is elsewhere, though they do not even come close to caring for all the needy. A certain number of these are people who are well able to care for their bills and, by hook or crook, gain admittance to these clinics. It is a task to stop them once they have passed the doors. The social service workers do the best they can, but they are tricked in many ways into putting their stamps of approval on undeserving individuals. These individuals are depriving some one who is needy.

I have been in homes to see patients where I had not the conscience to make a charge, and the responsible party has said to me: "I will pay when I can, Doctor." I would answer by saying, "All right." Of course there are any number of "dead beats" with whom one comes in contact, but they can always be spotted. The ratio of needy in the city and in

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the country is widely separated. There are many more in the city according to the population than in the country, for the farmer can grow some of his own foodstuff, and thereby relieve some of the pressure. His neighbor who might be needy can usually get his foodstuff from the adjoining farms for a small amount of work.

The community spirit should be to help the needy where they deserve it, and this should be determined by a social worker who knows almost every one in his or her particular territory. This would eliminate many people who are masquerading as needy. The doctor could cooperate and attend people who are really in need of medical aid. This would lift a big burden from his shoulders for he would gladly give to those who deserve it. The spirit of cooperation should prevail in every integral section of the country, every one share the burden and not let just a few do all the work. There is no definite plan to work on, as each city, town or community has its own problem to work out. It should be that every individual answer his responsibility, and thereby make a large responsibility shared by all. No one will have too much then.

The church should be the center of all activities for the poor, medical or otherwise. Candidly, without malice or prejudice, I do not think that the church organizations have lived up to their opportunities. I think, however, that it is due to lack of leadership. Too much attention has been devoted to preaching and the social side of the church, and practically none to the people who cannot help themselves.

Conclusion: The following is an outline of the responsibility of the laity to the indigent. (1) Determine who the indigent are, and then work out their needs for them—whether medicine, shelter, clothing or food. (2) Then appoint a committee to see that these things are cared for, but not let one committee serve too long; always make frequent changes. (3) If it is medical, have a medical committee attend to it, and determine whether it be tonsils, hookworms, food deficiencies, operations, deliveries or whatnot. (4) Attend to all of these as speedily as possible, and allow no one who is deserving to go lacking.

Lincoln's speech at Gettysburg said "that all men are created equal." Possibly so, but they do not remain so.

CHILDBIRTH*

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Panama City.

Ladies and Gentlemen: Greetings from the Florida Medical Association. We, as physicians in the great State of Florida, feel it is our duty to preach and teach preventive medicine and surgery just as it is our duty to prescribe and treat sickness and injury. With few exceptions, we make our livelihood by virtue of the misfortunes of our fellowman, and looking at it from a mercenary standpoint we should go about telling people how to get sick. However, I believe you will agree with me, when I say that if the layman would do as much toward prevention of disease as the doctors do, then we would make more progress toward better health. Yes, 'tis true, the health problem, both preventive and curative, is our business but we need, we beg for, and we must have, the help and cooperation of the laymen, individually and collectively, if we go very far with our constructive health program.

If our nation continues to progress and prosper the process of "having babies" must go on, so let us for the moment think about the ever-present, too often disasterous, procedure called "childbirth." The physicians who are members of organized medicine in the State of Florida are having to apologize for our high maternal and infant mortality and morbidity rates as compared to those of other localities. We do not feel it is altogether our fault for we believe the victims are largely to blame. To some people giving birth to a child is just a procedure that needs no thought or care,—just let Nature take its course. These people do not consider their future health or what kind of offspring they produce. We hope that education will change their attitude and inspire them to make an effort to obtain healthy bodies and produce strong, healthy babies. These poor, ignorant and irresponsible people will have to be reached by public health organizations, church and charitable organizations and by legislation.

To those of you who are intelligent and have a sense of responsibility; who want to

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produce the right kind of offspring, not only for your own pleasure and happiness, but that your children may be mentally and physically fit to sustain and better a nation; to you who wish to remain healthy enough yourselves to care and prepare them for their part in life, I want to direct my remarks. It is true that many women become pregnant not by choice, would like to have the pregnancy interrupted, and often do. I presume we will have these with us always to elevate our maternal mortality and morbidity rates, as birth control, sterilization and pregnancy preventive measures are yet far removed into the future. There are many young, healthy and intelligent women who are eager to have children—some so eager that they adopt them—but for some known or unknown reason they cannot have a baby of their own flesh and blood. To these women, also their husbands, I extend my heartfelt sympathy. God gave to most of us the power to create and reproduce our own kind, and no greater happiness can come to a family than when the stork brings a gift from heaven, especially when the event has been planned, wanted and anticipated.

It is not always the ignorant and poverty stricken woman who will go through a pregnancy with a carefree attitude, neglect herself and be unmindful of the unborn baby; our intelligent and well-to-do women are guilty of the same conduct. Babies being born is an everyday occurrence; probably this is why it is looked upon too lightly. But individually it is not an everyday occurrence, and is indeed a noble and heroic feat. Just because giving birth to a baby is a normal and natural procedure does not mean that it does not carry with it fear and danger. Any woman who assumes the task of motherhood should be honored and glorified for her bravery and efforts, for every woman born into the world cannot become pregnant; everyone that becomes pregnant cannot carry the pregnancy to full term; everyone that carries the pregnancy to full term cannot have a living and healthy baby; and everyone that delivers a living and healthy baby cannot live to realize her accomplishment. This, my dear friends, is something to think about. However, I think the dangers and hazards of childbirth can be minimized to a great extent if a little forethought will be exercised. Very few people build a home without doing some planning or buy an automobile without doing some financing, so why not do some serious thinking before bringing a human being into the world lest you jeopardize your own health as well as the newborn babe.

Obstetrical care is divided into three main phases: prenatal, which is the phase from the beginning of the pregnancy until the beginning of labor or the actual birth of the baby; the actual birth of the baby; and the convalescent period, from the time of the birth of the baby until complete recovery, usually six weeks in duration. Now I would like to add another phase with all apologies to the authorities. This I will call pre-pregnancy stage. This is from marriage until conception or from complete convalescence until re-conception. This is the phase I consider very important and often neglected. Really I do not think a woman or man should marry with the expectation or possibility of having children without assuring themselves that they are physically fit or at least have a knowledge of their abnormalities. As soon as a woman marries right then she is a potential mother and should be mindful of the fact and conduct herself accordingly. At the very earliest convenience after marriage, if not before, a potential mother should take inventory of herself and be assured that she is qualified for the contest in which she may be called upon to engage. She should present herself to a qualified physician for a complete physical and chemical examination. This, of course, to a timid bride is oftentimes embarrassing, but she has a duty to perform and should know her possibilities and capabilities, her weaknesses and abnormalities, if any, with reference to her becoming pregnant. If after the examination she finds that she is not quite up to the peak of health, corrective measures should be instituted as far as possible to get to the peak of health. If she discovers that pregnancy would be to her disadvantage and would jeopardize her life and health, then I think she would be justified in seeking measures to prevent such a catastrophe. Too many women present themselves to

the doctor with an established pregnancy, and the doctor finds that they are not physically fit for the contest and cannot be made so due to such diseases as tuberculosis, heart and kidney disease, syphilis and even cancer. The situation then becomes terrifically complicated with disaster looming. To interrupt the pregnancy would jeopardize the life and health of the potential mother; to allow her to continue with the pregnancy would do likewise; then, too, religious beliefs have to be considered. So you can readily see the importance of this pre-pregnancy care. Therefore, I beg you who anticipate becoming mothers to do your part and cooperate with your doctor in a combined effort to establish and maintain health and happiness.

Next is probably the most important phase of obstetrical care, and this is prenatal care. As soon as a pregnancy is suspected the prospective mother should at once consult her doctor, put herself under his professional care, for the contest has begun and an able coach will aid considerably in carrying her through the game victoriously. The pregnant woman should be the most concerned about the affair and it is up to her to be assured that her welfare is being safeguarded. If it is within her power she should not tolerate indifferent treatment whether it be from her friends, relatives or her doctor. She should be concerned about her physical condition and want to know if her body functions properly. She should know the whys and wherefores of her blood analysis, blood pressure readings, weight recordings, and urine examinations. She should be eager to know what she should eat and wear and be especially curious of prenatal hygiene. She should be inquisitive about anything that might be puzzling to her. If she is pregnant for the first time she should be concerned about her pelvic measurements, that is, whether her bony pelvis is sufficiently large to allow the passage of a normal-size baby. She should remember that during this prenatal phase she is laying the foundation of this baby's life and health. She should strive most earnestly to give this little one the best she has.

The success of the second phase, the actual birth of the baby, largely depends upon the doctor. If he has the proper qualifications, a well prepared specimen to work with, and the proper environment to work in, then the outcome should be satisfactory.

Last but by no means least in importance is the convalescent phase. The success of this period depends largely upon nursing care and hygiene. Permit your doctor to be the guiding star especially during the first ten days of this period, for it is during this stage that you will receive much erroneous advice from friends and relatives. Just because most women are out of the sick bed and going about in ten days after the birth of their babies they should not consider themselves well, for it is the concensus of opinion of the authorities that convalescence is not complete for at least six weeks. They should be considered as obstetrical patients until this period has passed. At the end of this period all such patients should insist upon an examination to ascertain whether they have returned to normalcy, and if not, treatment instituted to correct any abnormality. Another examination should be made at the end of three months, for the best treatment we have at the present time for cancer is prevention and early recognition of its existence. Patients should insist that these measures be carried out.

I will not attempt to discuss the care of the newborn child, but I would like to say this: Mothers, please nurse your babies if possible. The modern trend is to shirk this duty, but I believe if a mother wilfully and deliberately refuses to nurse her babe at her breast she is sinning against her child and should be held accountable for the misdeed. After you have gone through the ordeal of bringing the child into the world healthy and happy, then it is your duty to do your utmost to keep it so, for there is nothing more beneficial to the baby than its own mother's milk.

A baby is not alone a woman's responsibility, and I have this to say to the husband and father. The task of having a baby is not an easy one. With the best of care and surroundings childbirth takes its toll too often, so the best you can afford is still not good enough for one who so unselfishly sacrifices for your pleasure and happiness.

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RADIO BROADCASTS

This issue of the Journal, containing some of the radio broadcasts, should be interesting from several standpoints: first because the articles are written with a message simply and directly put so that the lay public will readily understand, and, second, because they show the honest effort of our profession to educate the public in a dignified and disalarming manner.

It can be said, without fear of contradiction, that *all* advances in the healing art, have come through medical education, research, and practice. We know this to be fact, but the public does not. Why it does not is largely our fault. Is it possible that if the people knew that the Basic Science bill, for instance, said in substance, that the law required a knowledge equal to that of a high school graduate's, wouldn't they have turned out and demanded it? It all goes to show that we need the public, and they need us. We know it; they do not seem to. The reason is that they do not know the facts, are not educated in the advances made in medicine for their protection and cure, and are led by more able talkers and advertisers. Radio broadcasting is one way to reach all classes of homes, all walks of life and all environments. Results may be slow, but this is a cog in the great machine that we should keep going. Medical propaganda of the truth, let the ax fall where it may, will come out victoriously.

Next year we will probably, along with a continuation of medical history and facts, attempt to educate our audiences to the point of making them aware that medical legislation is for their good far more than the profession's protection. Both are inseparable, but what is our protection is also the protection of our citizens.

Anyone attempting to refute this statement, regardless of whom it may be, is misrepresenting facts which can be readily proved. Let us prove this to the general public, our friends, and our patients.

Each member of the Committee on Public Relations has carried out his work, and is due the appreciation of the Association. May next year be as successful as the past.

MEETING OF MEDICAL GROUPS IN ORLANDO

The Annual Medical Postgraduate Short Course was held in Orlando the fourth week in June. The Orange Court Hotel offered unusually good facilities for taking care of this meeting. The faculty was composed of well qualified medical instructors and those who attended, by their close attention during class periods, complimented the instructors. The popularity of this medical short course also was evidenced by an increase in attendance. A larger number of doctors was registered this year than ever before. Toward the end of the session 135 doctors were registered. The official figures and report will be shown later by the Committee on Medical Postgraduate Course. This committee undoubtedly will feel very much encouraged by the interest of the medical men who took the time to attend this meeting and so faithfully attended the lectures.

The officers and members of the Orange County Medical Society did their part to aid the committee and entertain the guests, in Orlando. The fifth annual picnic and barbecue was staged Thursday evening, June 24 at the Flamingo Club. After the splendid feast,

a troup from Tampa put on a floor show, one of the outstanding features of this show being an acrobatic demonstration by one of the girls in the troup. The attendance at this evening's entertainment numbered more than 200 doctor guests from far and near over the state, as well as some out-of-state doctors who were included among the guests.

The Executive Committee of the State Association met at the call of the Chairman and spent many hours discussing some phases of the statements made in Senator J. Hamilton Lewis' address before the House of Delegates of the American Medical Association. A resolution was finally adopted which was transmitted by the Association's secretary to senators and congressmen from Florida in Washington, to the secretaries of state medical societies and to the secretaries of the component societies of our Association. The committee was honored by the presence of Dr. Walter L. Bierring, past president of the American Medical Association, who sat in as a consultant member. A number of routine business matters were handled by the Executive Committee before adjournment.

The Council met at the call of its chairman and enjoyed a very pleasant and constructive meeting. Eight of the twelve councilors were present and plans were approved for holding annual meetings in each of the six committee districts. A committee on arrangements is to be the senior councilor, the junior councilor and the secretaries of the component societies in each district. The first meeting was scheduled for the Northwest District "A." You will find in this Journal a complete program. The councilors also planned a study of the doctors licensed in the state who are not now members of the Association. With the aid of the secretaries of component societies, the councilors felt they would be able to submit some valuable information concerning eligible prospects for membership in the various districts.

The chairman of the Committee on Public Relations called a meeting of his committee for Thursday. A number of routine matters were discussed and plans developed for further service over the radio during the coming fall and winter. In this Journal you will find a reproduction of broadcasts by this committee, over Station WRUF the past year.

PROTEST AGAINST SOCIALIZED MEDICINE

The following resolution passed by the Executive Committee in session at Orlando, June 24, 1937, has been transmitted to our senators and congressmen in Washington by the secretary of the Association and copies mailed to secretaries of state medical societies and the secretaries of our own component societies. Note editorial comment in this issue:

RESOLUTION

"WHEREAS, the report submitted by the Delegates of the Florida Medical Association to the annual session of the House of Delegates of the American Medical Association at Atlantic City, June 7 to 10, 1937, indicates that a plan is being contemplated by the Federal, Executive, Administrative and Congressional authorities to place the practice of medicine in the United States as it involves the medical care of indigent persons, under Federal Government control, and

"WHEREAS, the Executive Committee representing the House of Delegates of the Florida Medical Association hereby affirms its willingness to cooperate at all times with the proper authorities in order to secure adequate medical care for all indigent persons, yet at the same time is convinced that such care is distinctly a community responsibility and is properly a function of the local governmental unit and local medical profession, and

"WHEREAS, Federal supervision of the medical care of the indigent without local control by the component medical units of the various State Medical Societies will destroy those principles which maintain for the public the highest quality of medical service and the possibility of improvement in this service.

"THEREFORE, BE IT RESOLVED, that the Florida Medical Association in justice to the medical profession of the state, hereby records its unequivocal opposition to and its unwillingness to cooperate in any plan that involves federal supervision and control of medical practice in the United States and will combat this with every means at its command, and

"BE IT FURTHER RESOLVED, that a copy of these resolutions be forwarded to the secretaries of all state medical associations with the recommendation that similar resolutions be adopted by such associations, and

"BE IT FURTHER RESOLVED, that copies of these resolutions be forwarded to all of our congressional representatives in Washington."

AMERICAN BOARD OF SURGERY ORGANIZED

In answer to the widespread demand for an agency which will attempt to certify competent surgeons the American Board of Surgery has recently been organized. This Board is a member of the Advisory Board of Medical Specialties which includes all of the boards of certification for the different medical specialties which have been already organized. Since boards were in existence for the certification of practitioners of some of the surgical specialties such as ophthalmology, otolaryngology, obstetrics and gynecology, genito-urinary surgery and orthopedic surgery it is expected that the American Board of Surgery will be responsible for the certification of general surgeons as well as those practicing in the remaining specialized subdivisions of surgery.

Acting upon the invitation of the American Surgical Association the following surgical societies cooperated in the creation of the American Board of Surgery: the American Surgical Association, the Surgical Section of the American Medical Association, the American College of Surgeons, the Southern Surgical Association, the Western Surgical Association, the Pacific Coast Surgical Association and the New England Surgical Society. The first three of these bodies which are national in scope have three representatives on the Board. All of the other societies have one representative each. The representatives of the cooperating societies are nominated by the society which they represent and upon approval of the Board shall become members of it. The term of membership on the Board will be six years.

The Board will hold its first examination (Part I, written) on September 20, 1937. All inquiries concerning applications for this examination should be received promptly by the Secretary, Dr. J. Stewart Rodman, 225 South 15th Street, Philadelphia, Pennsylvania.

PROGRAM
FIRST ANNUAL MEETING
OF THE
NORTHWEST COMMITTEE DISTRICT (A)
Apalachicola, Florida

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FIRST GENERAL SESSION

Thursday, July 15, 3 p.m.
Armory

Call to Order—
J. S. Turberville, *Senior Councilor*

Brief Addresses by State officers—
Edward Jelks, *President*
W. Henry Spiers, *President-elect*
Shaler Richardson, *Secretary*
W. McL. Shaw, *Chairman of Council*

SCIENTIFIC SESSION

Presiding, N. A. Baltzell, *Junior Councilor*

1. "Appendicitis," Edward Jelks, *President*, Florida Medical Association, Jacksonville. Discussion: August E. Conter, Apalachicola.
2. "The Uses and Abuses of the Electrocardiograph," E. F. Wahl, Thomasville, Ga.
3. "Collapse Therapy in the Treatment of Pulmonary Tuberculosis," F. C. Moor, Tallahassee.
4. "X-Ray Diagnosis," O. W. Britt, Chattahoochee.
5. "Malaria," Mark F. Boyd, Tallahassee.

SECOND GENERAL SESSION

Senior Councilor Turberville in the Chair
New Business
Announcements
Adjournment

The preceding plans are an outgrowth of the meeting of the Council held in Orlando, June 24. The councilors who met last month have some very constructive plans outlined for extending and enlarging the work of organized medicine all over the state. In the past the Chairman of the Council or individual councilors have made an effort to extend the usefulness of the organization they represent but this seems to be the first constructive move of the entire Council as a unit to pull together in unified effort. A large portion of the responsibility and laborious work falls on the shoulders of the secretaries of component societies. This leadership and assistance by the councilors of each district will be welcome to those who have been carrying a heavy load in the past.

STATE NEWS ITEMS

Dr. Carl S. Lytle of Dunnellon and Miss Carolyn Endsley of Brooksville were married Sunday, May 30. Doctor and Mrs. Lytle will reside in Dunnellon.

* * *

Dr. Albert W. Lewis of St. Augustine has moved to Atlanta, Georgia. Doctor Lewis' local address in Atlanta will be 502 Medical Arts Building.

* * *

Dr. and Mrs. Robert H. Farringer of Hollywood will sail from New York for Vienna, Austria with Dr. George W. MacKenzie of Philadelphia for special work in otolaryngology for six weeks, after which they will tour through Italy, Germany and France. Mrs. Farringer will take a special course offered in the fine arts and music while in Austria. Doctor MacKenzie is taking a group of medical men with him from all sections of the country, all of them sailing on July 10 on the Holland American liner, Veendam.

* * *

The Twenty-second Annual Session of the American College of Physicians will be held in New York City with headquarters at the Waldorf-Astoria Hotel, April 4-8, 1938.

* * *

Dr. Maximilian Stern, Daytona Beach, left for New York the latter part of June. Doctor Stern expects to do some work in the hospitals of New York City and then to go to Canada for a vacation period, returning to Florida about the first of October.

* * *

Mr. and Mrs. Robert Hampton Wiggins of Jacksonville announce the marriage of their niece, Jewell Edith Wiggins, to Dr. Fauntleroy Harris Schnauss, Jacksonville, on June 5.

* * *

Dr. Irvin Abell, Louisville, Ky., surgeon, was chosen president-elect of the American Medical Association at its annual meeting held in Atlantic City, June 7-11.

* * *

Dr. Julius C. Davis of Quincy, President of the Alumni Association of the School of Medicine of Emory University, delivered his presidential address at the meeting in Atlanta, June 4, at the banquet. Other Florida doctors who appeared on the program were Dr. Homer Pearson of Miami who, on June 2, read a paper on "Prenatal Care" and Dr. Walter C. Jones who presented a paper on "Care of the Surgical Patient" on June 3. The meeting was held at the Grady Hospital, Atlanta.

* * *

The eighth annual meeting of the Florida Society of Dermatology and Syphilology was held in Jacksonville the week-end of June 6. A well attended skin clinic was held in the Duval County Hospital. Election of officers resulted as follows: C. A. Andrews, Tampa, president; Lauren Sompayrac, Jacksonville, secretary. Tampa was selected as the place of the next meeting which will be held October 20. In attendance were Drs. Elmo French, Wiley Sams and Rothwell Lefholz of Miami; C. A. Andrews and G. C. Bottari of Tampa; Alan Brown, J. L. Kirby-Smith, E. C. Swift, L. M. Sompayrac and J. F. Wilson of Jacksonville.

* * *

Drs. James M. Hoffman and Rudolph P. Stritzinger of Pensacola announce the removal of their offices to 1221 East DeSoto Street.

* * *

Dr. A. J. Logie, Director of the Bureau of Tuberculosis, Florida State Board of Health, has been recently elected to the American Academy of Tuberculosis Physicians and also to associate membership in the American College of Physicians.

The State Board of Medical Examiners held its semi-annual meeting in Jacksonville, June 14 and 15. One hundred forty-four applicants took the examination. Doctor Rowlett announced that the persons seeking licenses came from 32 states and the Dominion of Canada.

Dr. W. M. Rowlett, secretary-treasurer for 20 years and the veteran member of the Board, was re-elected to that office. Dr. J. C. Davis of Quincy was named vice-president of the Board. A complete report will be published later, after the Board members have had sufficient time to grade the papers.

* * *

IMPORTANT NOTICE TO DOCTORS

What kind of doctor are you? The public now has a legal right to know. Words or abbreviations clearly denoting the particular kind or branch of the medical or healing arts must appear in a conspicuous place at the entrance of your office or usual place of business. The lettering must be at least TWO AND ONE-HALF INCHES IN HEIGHT and ONE INCH IN WIDTH. Doctors are urged to see that they qualify without delay.

SENATE BILL NO. 154
A BILL TO BE ENTITLED

AN ACT TO REQUIRE PRACTITIONERS OF EVERY KIND OR BRANCH OF MEDICAL AND/OR MATERIAL HEALING ARTS TO PLACE AND KEEP AT THE ENTRANCES OF THEIR OFFICES OR USUAL PLACES OF BUSINESS WORDS OR PROPER ABBREVIATIONS DENOTING THE PARTICULAR KIND OR BRANCH OF THE MEDICAL AND/OR MATERIAL HEALING ART THEY ARE LICENSED TO PRACTICE.

A complete reproduction of the new law will appear in the August number of the *Journal*. Doctors are urged to comply with this new statute promptly.

* * *

A meeting of the two councilors and the secretaries of the component societies of the Northwest Committee District "A" was held in Marianna the latter part of June. Plans were completed for the first annual meeting of the doctors in this district. The meeting is scheduled for Thursday, July 15, at Apalachicola. The material for this Journal is now going to press so you may expect a full report of the meeting in next month's Journal.

* * *

In connection with the Designation Law which has just been put on the statute books by the last session of the legislature, our first observation of the effects was on the office door of the Chairman of the Committee on Legislation and Public Policy. The prefix, "Doctor," has been deleted and the greeting on the doctors' office door is now shown:

"J. C. Davis, M.D.
T. W. Griffin, M.D."

* * *

Dr and Mrs. O. E. Harrell of Jacksonville announce the birth of a son, Martin, on Monday, May 24, in St. Vincent's Hospital. Mrs. Harrell was formerly Miss Margaret Hughes.

* * *

Dr. M. C. Wilson of Miami sailed recently on the S.S. Roosevelt for London. He expects to spend some time in Germany, France, and Austria before his return.

* * *

Dr. C. A. Peterson and Mrs. Camille Burroughs Blanton of Jacksonville were married on June 16.

* * *

Dr. C. C. Collins of Jacksonville was recently re-elected chairman of the Duval County Board of Public Instruction.

* * *

A meeting of the Southern Railway Surgeons Association was held in Jacksonville June 8 and 9 and in St. Augustine June 10. Dr. W. A. Applegate of Washington is chief surgeon of the Southern Railway System.

* * *

Dr. L. Y. Dyrenforth of Jacksonville was recently elected to Associateship in the American College of Physicians.

* * *

Dr. James L. Chalker and Miss Mary C. Fore, both of Ocala, were married on April 14.

* * *

Dr. A. O. Morton and Dr. J. E. Harris of Sarasota sailed the early part of July for Vienna where they will do postgraduate work at the University of Vienna. Doctors Harris and Morton expect to spend two months abroad.

Fifty-eight members of the Florida Medical Association attended the recent meeting of the American Medical Association held in Atlantic City, June 7-11. Dr. Meredith Mallory of Orlando and Dr. Herbert L. Bryans of Pensacola represented our Association in the House of Delegates. Those who registered were as follows:

Bieker, Annette M., St. Petersburg
Black, M. Eldridge, Clearwater
Borland, James L., Jacksonville
Bransford, L. E., Jacksonville
Brown, Harold O., Tampa
Bryans, Herbert L., Pensacola
Chandler, J. R., Daytona Beach
Chapman, B. A., Jacksonville
Coleman, John A., Plant City
Collins, Chas J., Orlando
Dobrin, Max, Miami Beach
Doern, William G., Daytona Beach
Estes, J. L., Tampa
Feaster, O. O., St. Petersburg
Folsom, Spencer A., Orlando
Fox, H. H., Miami
Freidus, Elias, Miami Beach
Gwathmey, G. Tayloe, Orlando
Halton, Joseph, Sarasota
Hewlett, Frank W., Coral Gables
Hotchkiss, W. T., Miami Beach
Ira, Gordon H., Jacksonville
Jenkins, O. W., Chattahoochee
Klein, Lawrence A., Live Oak
Knowlton, R. H., St. Petersburg
Lynn, C. W., Orlando
Lytle, Carl S., Dunnellon
McCreary, A. B., Jacksonville
McEuen, H. B., Jacksonville
McPhaul, W. A., Jacksonville
Mallory, Meredith, Orlando
Mentzger, Claude, Miami
Mills, A. L., St. Petersburg
Mills, Herbert R., Tampa
Morton, Rosalie S., Winter Park
Murphy, Ralph D., St. Petersburg
Nichol, E. Sterling, Miami
Panettiere, Cayetano, Miami Beach
Perdue, Jean, Miami Beach
Quicksall, J. Braden, St. Petersburg
Quillian, Warren, Coral Gables
Richardson, Shaler, Jacksonville
Robertson, J. C., Chattahoochee
Sams, Wiley M., Miami
Shaw, W. McL., Jacksonville
Simpson, W. T., Winter Haven
Smith, Marvin, Miami
Sompayrac, Lauren M., Jacksonville
Sory, Bailey B., Palm Beach
Stewart, Joseph S., Miami
Stone, Alvord L., Tampa
Strumpf, Irving J., Jacksonville
Taylor, H. Marshall, Jacksonville
Upchurch, Noble A., Jacksonville
Wallace, Albert W., Miami Beach
Walters, Arthur L., Miami Beach
Welch, P. B., Miami
Withers, G. H., Miami Beach

* * *

Dr. A. R. Beyer of Tampa sailed for Europe the early part of July. Doctor Beyer expects to take two months' medical course in Vienna and will spend some time in Germany and France.

At the recent meeting in Atlantic City of the House of Delegates of the American Medical Association the two Florida delegates were appointed members of reference committees. Dr. Meredith Mallory of Orlando was made a member of the Committee on Hygiene and Public Health and Dr. Herbert L. Bryans of Pensacola was made a member of the Committee on Miscellaneous Business.

* * *

Dr. Joseph Halton of Sarasota won a prize in the golf tournament of the American Medical Association in Atlantic City. This prize was a $37.00 humidor.

* * *

Dr. Frank T. Barker of Tampa announces the removal of his offices to Rooms 514-15-16-17 Citrus Exchange Building, 205 Zack Street. Doctor Barker previously had his offices at 303½ Zack Street.

* * *

Dr. H. A. Barge of Miami has returned from a two months' trip to Georgia and Alabama. Dr. Barge attended his class reunion at Vanderbilt University the early part of June.

* * *

Dr. Jess V. Cohn of Hollywood recently spent several weeks at the Cincinnati General Hospital, doing research work in the neuropsychiatric field.

* * *

Dr. S. Marion Salley of Miami has recently returned from a brief visit in Tallahassee where he attended the wedding of his sister.

* * *

Congratulations to Dr. and Mrs. Duncan Owens of Miami Beach, upon the recent addition to their family—a girl.

* * *

Dr. Annette M. Bieker of St. Petersburg announced the removal of her office from the Power and Light Building to St. Anthony's Hospital, and her association with Dr. O. O. Feaster in the practice of radiology and physiotherapy.

* * *

Dr. F. A. Vogt of Miami has recently announced the removal of his offices to the eleventh floor of the Huntington Building.

* * *

Dr. Gail Chandler of Miami is vacationing in the Canadian wilds and other points west.

Dr. Charles L. Kennon of Miami spent his vacation in the western part of the United States.

* * *

Dr. Eugene C. Lowe of Miami returned recently from a short vacation.

* * *

Dr. E. J. Hall of Miami recently moved into his new clinic building on First Street.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

The Dade County Medical Society has arranged for a new meeting place. Future meetings will be held in the Ingraham Building on the second floor. Members of the society feel that this is an ideal place to meet since it is in the downtown section and convenient for parking, etc. The regular meeting date of the Dade County Society is the first Friday in each month.

The regular monthly meeting of the Dade County Medical Society was held Friday, June 4, at 8:30 p. m. A number of good papers were read and discussed. The first paper was by Dr. Arthur Walters on "Modern Management of Diabetes Mellitus." The second paper was by Dr. Dan Amerise on "Recent Advances of Present-Day Treatment of Snake Bites."

A resolution was adopted by the society, urging the members of the City Commission and the city manager of Miami to retain the present city health officer, Dr. George N. MacDonnell. The society went on record as disapproving the removal of any health officer for political expediency.

* * *

DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The regular monthly meeting of the DeSoto-Hardee-Highlands County Medical Society was held at 8 p. m. Tuesday, June 8 at Wauchula. Dr. A. A. Poucher was the presiding officer in the absence of President G. H. McSwain.

Dr. J. R. Boulware, Jr., of Lakeland read a paper on "Pediatric Practice in South Florida—a Comparative Study." Those entering into the discussion of this paper were Doctors Kirkpatrick, Sirron, Boorom, Cline and Martin.

The attendance at this meeting was a favorable representation of the membership. The following members were present: Doctors Poucher, Chandler, Kirkpatrick, Spears, Boorom, McKnight, Bevis, Kayton and Martin. Visitors included Doctors Sirron of Sebring, Pyatt of Bowling Green, Morlan of Moore Haven, Boulware and Cline of Lakeland.

* * *

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Pasco-Hernando-Citrus County Medical Society was held Friday evening, June 11, at Lacoochee. Dr. W. H. Walters, Jr., was host and a very delightful dinner was served at the "Bungalow."

Very interesting case reports were given by the following doctors: J. T. Bradshaw, G. R. Creekmore, S. C. Harvard, W. Wardlaw Jones and W. H. Walters, Jr. Dr. W. H. Cox of Brooksville attended as a guest and took part in the program. On motion made and carried, the regular July and August meetings will not be held. The September meeting will be held in Dade City on invitation of Dr. W. Wardlaw Jones. The following resolution was adopted by the society:

WHEREAS, God in His infinite wisdom hath seen fit to remove from our company one of our beloved members, Dr. Augustus B. Cannon, and

WHEREAS, Doctor Cannon was one of the organizers of and a member for years of the Pasco-Hernando-Citrus County Medical Society, and

WHEREAS, he by his winning personality and friendship did endear himself to each and everyone of his acquaintances, and

WHEREAS, he by his untiring efforts to do good in his chosen profession, was a great asset to his community, and

WHEREAS, we as members of the Pasco-Hernando-Citrus County Medical Society do feel deeply the loss of our beloved comrade,

THEREFORE, BE IT RESOLVED, that the Pasco-Hernando-Citrus County Medical Society express its sorrow in the loss of our friend; that a copy of this resolution be forwarded to his wife, and that a copy be spread upon the minutes of this society.

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PINELLAS COUNTY MEDICAL SOCIETY

A meeting of the Pinellas County Medical Society was held at the Clearwater Yacht Club on May 21. The principal paper presented at this meeting was "Practical Application of Vitamine D," by Dr. J. S. Hood.

The June 4 meeting of the Society was held at the Lions' Beach Club, Treasure Island, with ladies as guests. Swimming was enjoyed in the afternoon, followed by an old-fashioned basket picnic at 6 o'clock.

On July 2 the members of the Pinellas County Medical Society and the Pinellas Dental Society held a joint outing. During the afternoon the golfing doctors played the golfing dentists on the Pasadena and Lakewood Courses. Members and their wives who did not play golf enjoyed the beach facilities of the Pass-a-grille Beach Hotel where the golfers joined them for dinner at 6 o'clock. This was the second annual Medico-Dental outing.

* * *

SEMINOLE COUNTY MEDICAL SOCIETY

The regular June meeting of the Seminole County Medical Society took the form of a boat trip and barbecue. The St. Johns River was a very beautiful setting for the boat carrying the medical group and guests. The barbecue was held at Blue Springs, which was a delightful spot for the group who enjoyed the good food and hearty fellowship.

As guests on this occasion, members of the Orange County Medical Society and Dr. J. C. O'Dell, Jr., of Jacksonville, were entertained. In the late evening the party returned to the Sanford Municipal Pier with a unanimous vote that this was an outstanding occasion for the members and guests of the Seminole County Medical Society.

Words or abbreviations clearly denoting the particular kind or branch of the medical or healing arts must appear in a conspicuous place at the entrance of your office or usual place of business. The lettering must be at least TWO AND ONE-HALF INCHES IN HEIGHT and ONE INCH IN WIDTH. See page 66 of this Journal.

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MRS. A. K. WILSON
4437 Herschell St.,
Jacksonville

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My Dear Friends and Auxiliary Members:

For a lack of space in our column this month I shall not be able to give you a full detailed account of the fifteenth annual meeting of the Woman's Auxiliary to the American Medical Association, which was held in Atlantic City, New Jersey, June 6-11, 1937, with headquarters at the Traymore Hotel. But as soon as the minutes of this meeting are off the press, I shall see that each officer, chairman, and county president gets a copy, which will give you in detail far more than I could possibly crowd into this article.

To be able to attend this Convention as your official representative was one of the greatest privileges of my life. I wish that every one of you could have been there to absorb some of the delightful inspiration and information that always comes from such a meeting. Mrs. Gordon H. Ira, Jacksonville, attended as an official delegate, and Mrs. Herrman H. Harris, Jacksonville, was an alternate.

The Auxiliaries of Delaware, Pennsylvania, and New Jersey were hostesses, and too much praise cannot be given those splendid women for their efforts in making our stay in Atlantic City one of comfort and enjoyment.

On Sunday evening a National Board dinner was given in the beautiful Belvedere room honoring our national president, Mrs. Robert E. Fitzgerald, at which time members of the Board were introduced and given an opportunity for a lovely fellowship together. They were delightfully entertained with a musical program and several monologues.

Monday was devoted to preconvention Board meetings. At noon an informal lunch-

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GYNECOLOGY—Four Weeks Intensive Personal Course starting August 2nd. Two Weeks Intensive Course starting September 20th and October 18th.

FRACTURES AND TRAUMATIC SURGERY—Informal Practical Course; Ten Day Intensive Course, starting July 12th and October 11th.

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eon was served in the Submarine Grill. In the evening a "Get Acquainted Beach Party" was held at the Steel Pier where music, motion pictures, games and dancing were enjoyed.

Tuesday morning the annual Southern Breakfast, under the auspices of Mrs. Frank N. Haggard, president of the Southern Medical Auxiliary, was held in the Submarine Grill honoring Mrs. Robert E. Fitzgerald. Guest speakers were Dr. Frank K. Boland, president of the Southern Medical Association; Dr. Charles G. Heyd, president of the A. M. A.; Mrs. Samuel C. Red, Texas, first organizer of the Woman's Auxiliary; and Mrs. Robert E. Fitzgerald.

The general session of business opened at nine thirty Tuesday morning. The president, Mrs. Robert E. Fitzgerald, presided. She introduced the General Convention Chairman, Mrs. Carl Surran, who extended an official welcome and made several important announcements. Mayor C. D. White of Atlantic City was then introduced, and gave the welcoming address, presenting to Mrs. Fitzgerald the key to Atlantic City.

Many interesting reports were read by the officers and chairmen showing a marked increase in the activities of each department during the past year. There are more than 3000 new paid up members since last year, bringing the total membership up to 18,595. Special emphasis was given the New Record System, which all State and County treasurers are requested to make use of. The president's message was most outstanding. She attended five State Board meetings and eleven State conventions during the year, sending circular letters to all State Auxiliaries stating the aims and objectives of the organization.

At one o'clock a sea food luncheon was served at Hackney's Famous Sea Food Restaurant, where music was enjoyed and rolling chairs provided for the convenience of those attending.

Tuesday evening was open, so we attended the general meeting of the A. M. A. in the auditorium of Convention Hall. Dr. J. H. J. Upham of Columbus, Ohio, was installed as the new president The program of music by the Madrigal Singers, under Henry Hotz's direction, was very beautiful and impressive.

The Auxiliary's second general session of business was called to order on Wednesday



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morning by the president, Mrs. Fitzgerald. This meeting was given over almost entirely to State reports. It gave me great pleasure to read Florida's report of last year's outstanding work under Mrs. W. W. Harden, which reflected much credit to our State.

At one o'clock an Auxiliary luncheon was given in the American Dining Room. Luncheon music was rendered by the Traymore Trio. The principal speaker was Dr. Charles Gordon Heyd, president of the A. M. A. At four an "Exhibits Tea" was given in the Mandarin Room by Mrs. Ily Bier, chairman of exhibits, and her committee.

An evening of entertainment and refreshments was held in the American Dining Room on Wednesday night. Mrs. Franz Imhof was master of ceremonies.

A Postconvention Board meeting and group discussion were in progress Thursday, which proved a great benefit to the new presidents. A lovely luncheon and style show followed, and in the evening a most enjoyable "Bring Your Husband Dinner."

In summing up the whole convention meeting, "Self Education" was one of the highest points of discussion, and one which every doctor's wife should consider. In contacting lay groups, a doctor's wife needs to be well informed and tactful. The Auxiliaries are the doorways into lay groups. Women's organizations are knocking at the doorways and asking for guidance because communities and individuals are health-conscious. Therefore, the Woman's Auxiliary is the doorway through which the medical profession has an opportunity to enter and become the instructors, the guides.

(Mrs. S. M.) Minnie Ross Copeland,
President.

* * *

The State Auxiliary Board met June 24 with the Advisory Committee to the Woman's Auxiliary in Orlando's beautiful Orange Court Hotel. Mrs. S. M. Copeland of Jacksonville, as president of the Woman's Auxiliary, opened the meeting, and introduced Dr. Gordon H. Ira of Jacksonville, chairman of the advisory committee, who reviewed the Auxiliary's work for the past year. Among its accomplishments were the program for cancer prevention, examination of household servants for the control of social diseases, and

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the gratifying response to the essay contest on "The Problem of Ridding Florida of Tuberculosis" which was sponsored by the Auxiliary in the State high schools. In addition, Dr. Ira made suggestions for the new year's program which was followed by an enthusiastic round table discussion.

Dr. Edward Jelks of Jacksonville greeted the members as president of the Florida Medical Association. He expressed the appreciation of the Association for the work and high ideals of the Auxiliary, and asked cooperation in preserving the competitive spirit in medicine as conducive to the greatest public benefit and the advancement of science. Dr. L. C. Ingram of Orlando added his encouragement to the work the Auxiliary is doing in health education.

In her talk to the board, Mrs. Copeland stressed the importance of self-education to increase the value of Auxiliary work, and reported on the Auxiliary's meetings at the A. M. A. convention in Atlantic City, urging the local branches to send more delegates in the future to receive the inspiration and enthusiasm which these meetings give. She encouraged the members to listen to the radio health programs which are being sponsored by the A. M. A. over a nation-wide hook-up.

Following the meeting, the board was entertained with a delightful al fresco supper at the home of Dr. and Mrs. Frank D. Gray in Orlando. The members expressed their appreciation to Mrs. L. C. Ingram and her splendid committee of the Orange County Auxiliary for the gracious hospitality which they received.

* * *

An announcement of special interest to Florida Auxiliary members was the appointment at the national convention of Mrs. Gordon H. Ira, Jacksonville, as Historian of the Woman's Auxiliary to the A. M. A. It is gratifying to know that Florida again has a representative in the national affairs of the Auxiliary.

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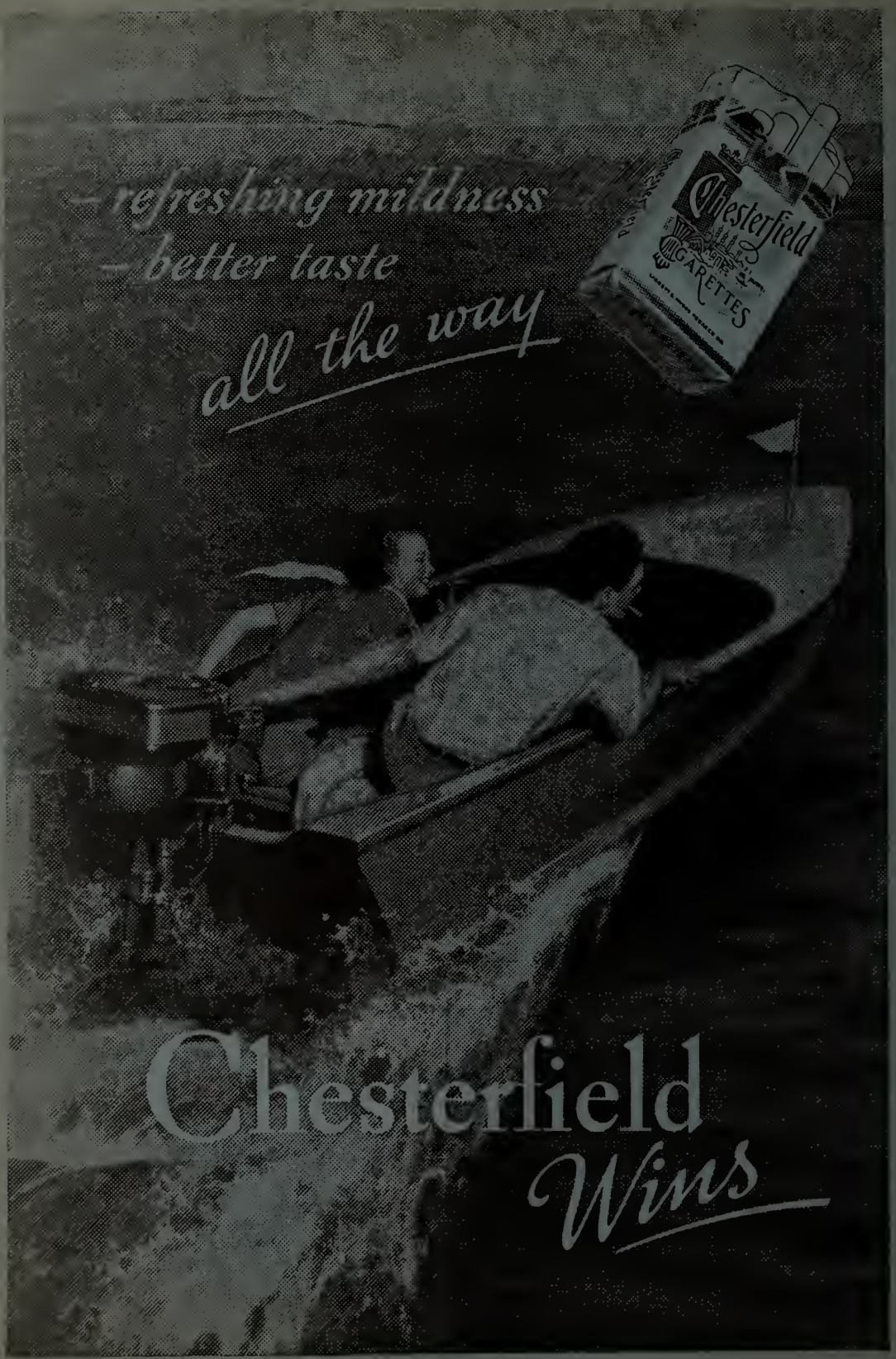
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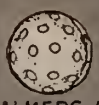
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Regarding the treatment of diarrhea, "In our experience, the most satisfactory carbohydrate for routine use is Mead's dextrimaltose No. 1."—*F. R. Taylor: "Summer Complaints," Southern Med. & Surg., pp. 555-559, Aug. 1927.*

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"Again, following the teaching of the originator of protein milk, the carbohydrate added should he the one that is most easily assimilated. Dextri-maltose is the carbohydrate of choice."—*R. A. Strong: The diarrheas of early life, Mississippi Doctor, 14:9-15, Sept. 1936.*

"If the stools are acid, green, and excoriating, a food high in protein and low in fat, and carbohydrate is indicated. Dried powdered protein milk is very ideal here—one to ten dilution. On the other hand, if the evacuations are brown, watery, and stinking with putrefactive odors, a proteolytic diarrhea, it will be of advantage to add a small amount of carbohydrate, a dextrimaltose preparation being very efficacious."—*A. G. Dow: Diarrheas in infants, Nebraska M. J., 20:22-24, Jan. 1935.*

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"After the preliminary short period of starvation, protein milk should be used. . . . When the diarrhea has been sufficiently checked, dextrimaltose may be added and gradually increased until from 4 to 6 tablespoons are being used."—*W. L. Denney: Acute nutritional disturbances of infancy, Univ. West. Ontario M. J., 2:192-137, April 1932.*

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In diarrhea, "Carbohydrates, in the form of dextri-maltose, well cooked cereals or rice, usually can be handled without trouble."—*B. B. Jones: A discussion of some of the commoner types of infantile diarrhea, and the principles underlying the diets used in their treatment, Virginia M. Monthly, 55:411-415, Sept. 1928.*

In the treatment of dysentery, "As a useful supplement, Bessau's thick rice water with 1 to 5 per cent dextrimaltose may be used, or soy bean milk, which also may serve as main nourishment in the rare cases of hypersensitiveness to cow's milk."—*O. Willner: Dysentery, in The Practitioner's Library of Medicine & Surgery, D. Appleton-Century Co., Inc., New York, 1935, vol. 7, p. 371.*

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In cases of diarrhea, "For the first day or so no sugar should be added to the milk. If the bowel movements improve carbohydrates may be added. This should be the one that is most easily assimilated, so dextri-maltose is the carbohydrate of choice."—*W. H. McCaslan: Summer diarrheas in infants and young children, J. M. A. Alabama, 1:278-282, Jan. 1932.*

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"When there has been a tendency to looseness of the bowels, a form of sugar which ferments but slightly, such as dextrimaltose, may be employed."—*W. Sheldon: The artificial feeding of infants, Practitioner, 134: 415-428, April 1935.*

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". . . I begin to add carbohydrates slowly, by replacing ¼ ounce Casec every two days with ¼ ounce of Dextri-Maltose, preferably Dextri-Maltose Number one. As a rule, this is tolerated. When one ounce of Dextri-Maltose is used, the Casec, of course, should be discontinued."—*J. W. Reed: The etiology and treatment of diarrhoeas of infancy, Virginia M. Monthly, 53:732-735, Feb. 1927.*

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In treating chronic diarrhea, "You do not need to starve such patients, but you select a diet of dried protein milk with the addition of dextrimaltose given in small three-hourly feeds, or soured milk, or an ordinary half-cream dried milk, or a whey mixture."—*R. Hutchison: Lectures on Diseases of Children, ed. 7, William Wood & Co., Baltimore, 1936, pp. 26, 65, 71-72, 76.*

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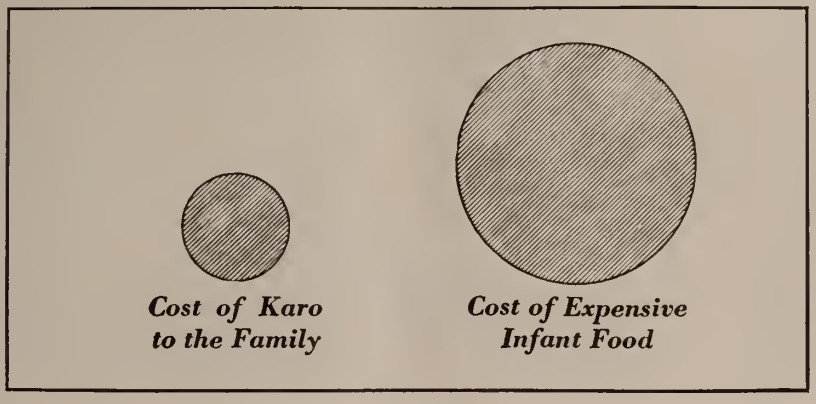
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CORONARY DISEASE*

WILLIAM C. BLAKE, M.D.,
Tampa.

Since Herrick,[1] in 1912, presented the earliest complete clinical description of sudden coronary occlusion, the subject of coronary disease has received constantly increasing attention. Particularly in the last ten years has interest been stimulated both by increased knowledge of this disease and by the evident marked increase in its incidence. No longer in a middle-aged or elderly person is "acute indigestion" ascribed as a cause of death without due thought and consideration. A decided increase in the incidence of coronary disease within its own ranks has further stimulated the interest of the medical profession. That 36 per cent of deaths in a single recent year among physicians in the United States resulted from heart disease is of peculiar significance to every member of the profession. What physician more than forty years of age, experiencing some vague discomfort in the anterior chest, has not stopped to wonder if he were developing angina pectoris? Coronary disease in its various aspects has properly come to occupy the universal attention of the profession at the present time.

In a recent article Cannon[2] called attention anew to the changing incidence of various types of disease. Infections have in general greatly declined, and disease dependent wholly or in part on nervous trauma has greatly increased. The suicide rate in the United States for 1932 was over 50 per cent higher than during the five years after the World War, the steady rise during the period of depression meaning for that year alone an increase of more than 6,000 suicides. This unprecedented rise, the vast increase in the neuroses, and the extraordinary proportions which cults of mental healers continue to attain not only indicate an altered emphasis in disease but also suggest that the medical profession may not now be sufficiently aware of the remarkable shift nor as yet considering adequately the role of emotion in producing bodily disorders.

Etiologic factors are difficult to evaluate but the hustle and bustle of modern life with its attendant worry, fear, and frustrations have undoubtedly played a very appreciable part in effecting these changes. Diseases suggesting strain which have nearly trebled in the last three decades are those of the heart and blood vessels. Statistics show that in New York and Massachusetts angina pectoris, at least emotionally stirred if not emotionally started, now claims three times the number of victims it did in 1900. Levy, Bruenn and Kurtz[3] found that the autopsy diagnosis of coronary disease at the Presbyterian Hospital in New York increased from 17.8 per cent for the decade immediately preceding to 30.4 per cent for the decade from 1920 to 1930.

Heredity is one important etiologic factor. Could one select parents and grandparents who had remained free of evidence of coronary disease, he would himself largely escape its consequences. The type most susceptible to it is the robust, dynamic person who is inclined to be somewhat overweight. Can it be that through the process of natural selection this energetic type of individual has been propagating his kind at a greater than average rate? What part has the nearly universal use of tobacco played as a contributory factor? Why is this disease much more common in men than in women? The proportion is three or four to one; yet hypertensive heart disease, likewise of arteriosclerotic origin, is much more common in women. These questions cannot be fully answered at the present time. The fact remains, nevertheless, that mortality tables and autopsy statistics show that coronary disease is actually on the increase and that the increase is beyond the proportion which could be explained on the basis of increased longevity.

The term coronary disease is practically synonymous with the term arteriosclerotic heart disease. The disease is dependent on

*Read before the Sixty-fourth Annual Meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, 1937.

arteriosclerotic changes in the coronary arteries with consequent puckering and thickening of the arterial wall and narrowing of its lumen. When sufficiently marked, these changes cause a reduction in the supply of blood to the myocardium and thus produce their deleterious effect on the heart. The effectiveness of the heart quite as much as of any muscle or of any organ of the body is dependent on an adequate supply of blood, and when this supply is reduced or interrupted, obviously its effectiveness is correspondingly reduced. The extent of the resulting degenerative process is extremely variable for it may be localized or generalized. As sequelae there may be local or extensive areas of fibrosis in the myocardium. Just as a lesion damages the brain in varying degree and extent and has varying effect according to location, so the heart suffers impairment analogously when there is a reduction in or an interruption of an adequate supply of blood to the myocardium.

In coronary disease the pathology manifests itself clinically in three ways: (1) as angina pectoris; (2) as coronary thrombosis with myocardial infarction; and (3) as increasing myocardial weakness either with or without the presence of the two preceding syndromes. It is important at the outset to keep in mind that angina pectoris and coronary thrombosis, often regarded as separate and distinct entities, are in reality but phases of coronary disease, merely incidents or even accidents in this degenerative process.

From a clinical standpoint it is necessary to go into great detail regarding the symptomatology of angina pectoris, but for the purpose of this paper I shall not do so. The varying degree of substernal pressure or tightness with radiation to the left arm or to both arms and frequently to the angle of the jaw is familiar. Typically there is present a sensation that produces apprehension, even fear of impending death, and inclines the patient to remain motionless. The diagnosis must be made from the clinical history in the vast majority of cases, and for this reason a most painstaking account of the patient's symptoms should be considered together with a careful evaluation of the emotional and psychic factors which may be present. Frequently too little consideration is given to the location of the pain. The typical pain is substernal although it often radiates over the entire anterior chest, especially the left chest. When the patient places the pain over the apex of the heart, extracardiac pain or the pain accompanying neurocirculatory asthenia or other neurotic states should be considered. The duration of the pain in angina pectoris is also important. It may last for a few seconds or continue for twenty or thirty minutes, if the patient remains quiet during the seizure, but it is not the momentary flash so often complained of nor is it a long continued pain.

In atypical cases, before making a diagnosis it is necessary to evaluate the state of the entire cardiovascular apparatus. The presence of arteriosclerotic changes elsewhere in the body or such evidence of disease of the heart as cardiac enlargement or respiratory distress on moderate exertion, not otherwise explained, inclines one to the diagnosis of angina pectoris when the symptomatology is borderline. The reverse is likewise true. Finally, the electrocardiographic findings are of great value. While severe coronary disease may be present without manifesting itself in electrocardiographic changes, yet the disease may be definitely diagnosed in the absence of suggestive symptomatology through electrocardiographic studies. The electrocardiogram does not show angina pectoris, but it does give evidence of the presence of coronary disease, in the development of which angina pectoris is but an incident.

Coronary thrombosis and cardiac infarction may occur slowly over a period of days or weeks or may occur suddenly, the symptomatology depending on the rapidity with which the occlusion takes place. If the occlusion develops slowly and no excessive strain is placed on the heart, there may be no symptoms at all, or shortness of breath may be the only symptom. On the other hand, if the infarction takes place suddenly, the symptomatology is dramatic with severe vise-like pain in the substernal or sometimes the epigastric region with characteristic radiation to the arms and neck. If the pain is substernal, the diagnosis is easily made. If, however, it is largely epigastric, as it occasionally is, it may simulate pain present in such conditions as gall bladder colic, pylorospasm or ruptured gastric ulcer. Careful differentiation and exact recognition are of paramount importance

since recovery depends upon a proper understanding of the ensuing pathologic changes. An area of myocardium has been deprived of its supply of blood and necrosis follows just as it would in a finger with a string tied tightly enough at its base to cut off circulation of the blood. Recovery depends upon the size of the area involved and the facility with which collateral circulation is established. Nitroglycerine, which relieves the pain of angina pectoris, was formerly thought to be of considerable diagnostic value in differentiating between angina pectoris and coronary thrombosis, but its value in this respect has been lessened by the studies of Butsch, McGowan and Walters,[4] which showed that the nitrates usually relieve cholecystic spasm. If a substernal pain lasts an hour or longer with the patient at rest and is not relieved by nitrates, the chances are overwhelmingly in favor of the existence of coronary thrombosis. The occurrence after two or three days of slight fever and slight leukocytosis is to be considered as confirmatory evidence.

In no condition is a carefully taken history of more importance than in coronary disease. It should be remembered that the pain of coronary insufficiency is almost invariably substernal in origin. Often confused with it is the "heart ache" or precordial aching, maximal as a rule around the left breast, which accompanies neurocirculatory asthenia. The accompanying sensitiveness of the skin over this area is an important clue to its proper interpretation as is also the presence of the other cardinal symptoms, namely, palpitation, respiratory discomfort and exhaustion. Short, sharp stabs of pain in the precordium are frequently due to premature beats and are to be explained as is the precordial aching of neurocirculatory asthenia. Both are of minor significance. They are due to functional disturbance of the heart and occur only in the individual with a sensitive nervous system. To confuse these symptoms with those of coronary insufficiency would mean condemning to invalidism one who, with exercise and reassurance, could be restored to health and vigor. Fewer diagnoses of coronary occlusion would be made if some of the other causes of pain in the anterior chest were kept in mind. Among them are pulmonary embolism with infarction resulting from endocarditis or following surgical interference, pericarditis, spontaneous pneumothorax, pressure from aortic aneurysm, and dissecting aneurysm with its tearing, excruciating pain, which radiates through the chest and down the back to the legs. All of these conditions can frequently be determined from the history alone if sufficient care has been exercised in eliciting the complete symptomatology.

The clinical diagnosis of "chronic myocarditis" is still freely used when the underlying pathology is that of coronary disease. A true inflammation of the myocardium occurs in severe cases of diphtheria, rheumatic fever, and, more rarely, in such diseases as typhoid fever, pyemia and cardiovascular syphilis. The use of the term should be restricted to instances in which a true inflammatory change is present.

Coronary disease manifesting itself clinically simply by diminished supply of blood to the myocardium and consequent myocardial weakness has an insidious onset, gradually producing weakness and dilatation of the heart muscles with consequent breathlessness on exertion. Indeed, in a middle-aged person the presence of dyspnea in the absence of valvular heart disease, hypertension, extensive pulmonary change or severe anemia usually means coronary disease. This third clinical manifestation is the least spectacular but it is important to realize that frequently in the course of time it will develop into the more dramatic syndromes of angina pectoris and coronary thrombosis. As already stated, these two manifestations of the disease should not be viewed as separate entities but rather as incidents in the progress of this degenerative process.

Obviously, it is important to distinguish carefully between the three clinical aspects of the disease. Angina pectoris, although at times emotionally stirred, is usually an effort syndrome under the handicap of which a patient may continue a more or less normal life within wise limitations when the condition is properly understood. On the other hand, acute coronary occlusion demands complete and prolonged rest in bed. It is, therefore, important in treatment to differentiate between the various manifestation of the process.

The electrocardiograph has become established as a very important aid in evaluating the efficiency of the coronary circulation. Its value is firmly established in the diagnosis of recent occlusion, but is not fully appreciated in the detection of the milder grades of coronary insufficiency. This early information is really more important than localization of a lesion after infarction has taken place. It is not within the scope of this paper to present a detailed description of the electrocardiographic changes indicating coronary insufficiency, but during the last few years sufficient data have been accumulated to make possible detection of coronary insufficiency with a great degree of accuracy.

Coronary disease is a progressive process dependent on many factors as yet poorly understood. Nevertheless, if greater effort were made to detect its presence at an early stage of development, many safeguards could be thrown about the patient which would greatly prolong his life and do much to avoid the catastrophe of cardiac infarction.

SUMMARY

That coronary disease has greatly increased in recent years is generally accepted. It is a progressive degenerative process manifesting itself clinically as angina pectoris, coronary thrombosis with myocardial infarction, and increasing myocardial weakness with or without these syndromes. The pain which characterizes it is almost invariably substernal. Consideration of other causes of pain in the anterior chest is important in diagnosis, as is also a carefully taken history. Of great value, both in the diagnosis of recent occlusion and in detecting milder grades of coronary insufficiency, are electrocardiographic studies. The insidious onset and progressive nature of coronary disease make early detection of this degenerative process particularly important. Angina pectoris and coronary thrombosis are but phases in its development.

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DISCUSSION

Dr. E. Sterling Nichol, Miami:

The author's description of coronary disease has been delightfully clear but necessarily brief. I should like to elaborate on one phase of the subject that interests me, namely, its prevalence. The author has expressed the current opinion that the stress and strain of modern life accounts in some measure for the acknowledged increase in coronary disease. The slower tempo of life induced by the subtropical climate of southern Florida may account for a lowered comparative incidence of coronary disease in this area, for the disease is seen infrequently among those who have lived in this environment a good share of their years. Statistics are being collected at the present time of both clinical and pathological character, to substantiate this clinical impression. It is necessary of course to weed out the hordes of "coronary cases" that one sees here in the season, among the tourists, for patients and physicians alike have learned during the past ten years that this is the ideal climate for the victim of coronary disease, hence his presence with us during the winter in such numbers. Other factors than the lessened strain of life in this climate may eventually be shown to account for the less common incidence of coronary disease here, for all students of the subject do not concede that strain accounts for the increase in coronary heart disease. For example Levy, in his recent volume, "Diseases of the Coronary Arteries and Cardiac Pain" points out that although the deleterious effect of worry and nervous strain on a heart already disabled is clear, yet proof that sustained nervous tension can induce coronary sclerosis or thrombosis in a previously normal heart, is lacking.

The influence of hypertension on coronary disease merits comment, for much evidence has been adduced showing that coronary sclerosis and thrombosis occur with greater frequency in the hypertensive patient than in individuals with normal blood pressure. Hypertension also impairs the prognosis on the average in patients who have suffered coronary thrombosis. Diabetes also seems to pre-

dispose to the development of coronary disease.

Dr. Louie Limbaugh, Jacksonville:

Doctor Blake has given us a very interesting paper. We have perhaps read more about this disease in the past decade than any other form of heart disease. It is probably because of the increased knowledge of the condition that more cases have been correctly recognized and treated. One is impressed by the fact that the average general practitioner today does recognize coronary thrombosis. He can do this without the aid of the electrocardiograph. In other words, a general practitioner in the rural district can make a proper diagnosis today because he knows what symptoms to expect, the character of the pain, the elevation of temperature, the drop of the blood pressure, etc.

It is hoped that the men in general practice who have heard Doctor Blake's paper will be encouraged by the fact that by careful study and observation they can make a proper diagnosis fifty miles away from the electrocardiograph just as easily as though one were available on the same floor.

Dr. Gordon H. Ira, Jacksonville:

One thing we are all interested in, is, what can we do for the patient?

I have found one drug very valuable when the patient is suffering from acute pain, and that is an intravenous injection of aminophyllin. In several cases the patients have been given considerable relief and in certain others, almost complete relief.

Another point in the treatment of the pain of angina is the use of trichlorethylene perles. The same as has been used in the treatment of tic douloureux. It was suggested to me by Dr. Willius, chief of the section on cardiology at the Mayo Clinic, about a year ago. It should be emphasized that it does not give immediate relief; its effect seems to be cumulative. This undoubtedly accounts for its apparent failure in some cases of trifacial neuralgia. The perle should be broken and inhaled twice daily for the first week; twice daily on every other day the second week; and twice daily on two days a week, Tuesdays and Fridays for instance, thereafter. It is not a cure for the cause but, in my experience, in a number of cases very definite relief has been obtained.

Dr. William C. Blake, Tampa, (Concluding):

The main object of my paper was to encourage thinking in terms of coronary disease and to emphasize the importance of differentiating between angina pectoris and coronary occlusion. Unless this distinction is speedily made the patient will often pay for the mistake.

Coronary disease can often be diagnosed clinically but the electrocardiogram will usually give invaluable information that cannot be gained in any other way. A few years ago the principal value of the electrocardiogram was in differentiating cardiac irregularities, the majority of which are functional and which can usually be recognized clinically. During recent years sufficient data have accumulated to make its principal value lie in the early detection of coronary disease and in differentiating between angina and occlusion.

In this connection I would like also to say a word about reading too much in electrocardiographic films. Unless the evidence is conclusive, consider carefully the various extracardiac conditions capable of producing anterior chest pain.

THE PROBLEM OF URINARY CALCULI IN RELATION TO THE GENERAL PRACTITIONER*

Louis M. Orr, II, M.D.,
Orlando.

During recent years the problem of calculi in the urinary tract has been given a most important place on the calendar of our research centers. The results of these experimentations have been so encouraging that it is now the general feeling that a lengthy step has been taken in the direction of a solution of the baffling problem of the cause and method of prevention of urinary calculi. To evaluate these results will take the necessary clinical trial. Restraint must be placed upon the ever present tendency toward over-enthusiasm which so frequently follows the announcement of new medical developments. It is enlight-

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ening, however, to learn that practically all of the work which has received so much publicity of late is but a repetition and confirmation of work done many years ago. The recent experiments with rats in which they were given a diet deficient in vitamin A resulting in the production of renal calculi are but a continuation of the work of Osborne and Mendel, carried on in 1917. In 1923 Wilson and DuBois showed the pathological changes in the mucosal epithelium in humans which resulted in keratinization when those same individuals were fed on diets deficient in vitamin A. McCarrison, working in India in 1917, gave to a group of rats the same type of vitamin deficient diet used by natives of a region in which urinary calculi were quite common. These rats likewise developed calculi of the same type as the natives. He thus found that avitaminosis was an important factor in stone production. He likewise found that by adding cod liver oil, butter and other vitamin containing foods to the diet stone formation could be prevented in some cases. The work of Higgins which has been published and republished since 1931 shows that very little has been added to these original investigations except for the construction of the so-called "acid ash diet" which means simply a diet containing the principal acid producing foods which as an end product of metabolism give rise to a higher degree of urinary acidity.

The undue amount of publicity given this diet by the lay press has resulted unquestionably in much suffering and damage to patients with urinary calculi which ordinarily would have been avoided. This only emphasizes the fact that the dissemination of medical knowledge should be entrusted to and through medical periodicals only. The popularizing of medical research and experimentation by press agent methods should not be condoned by the profession and it is unfortunate that some of our larger clinic groups attain publicity in this manner. This is all said for due reason as under my own care have come patients with renal calculi who have caused themselves irreparable damage by using the diet when it was not indicated and in the false belief that in this way they could avoid surgery.

The various geographical stone areas of the world and the many theories relating to their formation are interesting. The stone areas in Great Britain are confined to certain districts. In Europe stone is very common in Holland and in the southeast of France. In southern China stone is frequently encountered and in the northern part almost entirely absent. Certain parts of India are famous for stone and in others it is just as uncommon. In Holland, where renal stones are very common, the drinking water is quite free from lime-stone and in Switzerland where stones are rarely found the water is very hard and charged with calcareous material. It has been found to be generally true that stone is more prevalent in people living on a monotonous diet composed principally of carbohydrates rather than those used to a well balanced and varied diet.

In our own country the principal stone producing areas are Southern California and in our own particular section of Florida, the southern portion. This fact alone should stimulate our interest to a better understanding of the processes that aid in producing calculi as well as those which are presumed to be important in their prevention.

Some recent writers have attributed the presence of calculi in these areas to the fact that the inhabitants live on a diet low in vitamin A and acid ash food. This would seem to be a reason entirely without foundation. It could hardly be assumed that people in any one section of a civilized country could isolate themselves to a diet deficient in milk, butter and meats and such a statement is in no sense of the word correct. What is probably more nearly correct is that inhabitants in warmer climates do not use a sufficient amount of fluids by mouth and as Mr. Winsbury-White has stated, the extreme fluctuations in temperature by day and night thereby altering the concentration of urine, may be a factor in stone production. Strangely enough, stones are quite prevalent among the Norwegians whose diet is very heavy in vitamin A and who do not live in a warm climate.

Mr. White has found in a recent study that for the different ages of life calculi have been found in different parts of the urinary tract. In the early years of life stone formation is more common in the urinary bladder, in the middle years in the kidney and in the later years again in the bladder. The cause in the first two ages might be said to be dietetic and in the latter years probably due to obstruction at the vesical outlet.

The negro race and the Eskimaux seem immune to the formation of calculi. Heredity is of no importance although some families have been known to have stone when living in widely separated areas.

The recent work of Albright, Aub and Bauer has shown that in cases of hyperparathyroidism caused by tumor of the parathyroid there arises a disturbance in the calcium and phosphorus metabolism with associated increase in the excretion of both calcium and phosphorus in the urine. It was likewise found that about one patient in every four with hyperparathyroidism developed urinary calculi. These findings are important as a step forward but it must be remembered that one may see many hundreds of patients with calculi without seeing a single one with parathyroid disease.

The role played by infection as a causative agent in the formation of calculi is a most important one and has many adherents. Rosenow of the Mayo Clinic has been able to produce stones in experimental animals by the injection of a specific organism obtained from the teeth, tonsils and urine of patients afflicted with recurrent calculi. These organisms which were a strain of streptococci were placed in the devitalized teeth of dogs. Stones appeared in the kidneys in over 60% of all the animals. Rosving states that 71% of all recurrent stones in human kidneys are due to some bacterial infection. Hagar and McGath have isolated from patients suffering with alkaline encrustations of the bladder an organism known as the proteus ammoniae bacillus. By injecting cultures of this bacteria into the bladders of dogs in which a chemical cystitis had been produced a chronic alkaline encrusted cystitis resulted. This organism is unquestionably one which has certain stone forming properties by virtue of its urea splitting properties.

Stasis in the urinary tract associated with infection is undoubtedly responsible in many instances for the formation of renal calculi, but stasis alone can hardly be considered a factor. On the other hand, the larger number of improperly draining kidneys which are infected do not show calculi.

Apparently it is necessary that the infecting organism be of a specific urea splitting, or stone forming type, and is of greater importance than the stasis itself. In so many cases of bilateral nephrolithiasis the pyelogram shows stones located in the pelves of the kidneys but in no way interfering with the drainage of urine. It would seem that the nucleus of the stone in the early days of its formation would be easily passed in this type of kidney. Much importance has been attached to the role of the urinary colloids and crystalloids in the formation of calculi and it was Ebstein who first put forth the hypothesis of the protective action of the colloids. He was of the opinion that as long as the urinary colloids could keep all the crystalloids in solution there would be no opportunity for crystalline precipitation and organization into a stone. When this protective relationship was destroyed stone formation resulted. Keyser has proved conclusively that Ebstein's hypothesis is correct in that he has been able to produce urinary stones by causing an excessive secretion of crystals in the urine to such an extent that the protective colloids were unable to hold the crystalloids in solution and as the crystalloids are insoluble in urine, crystallinization into stone resulted. Not only is it necessary for an excessive amount of crystalloids to be present in the urine to produce calculi, but any interference to the normal action of the colloids, be it an error in metabolism or infection, will likewise cause a precipitation of crystalline material.

One of the first reports of intentional dissolution of renal calculi was by Cromwell in 1924. He was able to cause the complete disappearance of a cystine calculus by intense alkalinization. Higgins reports 21 patients in whom calculi were successfully dissolved by prescribing a high Vitamin A acid ash diet. These patients are presumed to have had stones of the alkaline earth type. Lazarus and Rosenthal, in a quite recent report, followed the routine as laid down by Higgins and were not impressed with the efficacy of the diet after a study of 121 patients with urinary calculi. It was their feeling that Higgins' small group of patients had stones of loosely formed phosphatic particles which had not coalesced into solid stones and were influenced by a highly acid urine to the state of dissolution.

All of the aforesaid theories of formation of calculi are of but little practical value to the general physician, but in order to properly and intelligently care for a patient suffering from stone in the urinary tract a comprehen-

sive understanding of the various modes of therapy are necessary.

It is not necessary at this time to review the various surgical procedures which are available for the patient with urinary calculi. They have all been developed to a point of preciseness which leaves little to be added.

The use of the so-called dietary form of treatment calls for a clear conception of the indications, contraindications and limitations and unless they are quite intelligently followed the patient is more likely to be harmed than benefited. The high vitamin A acid ash diet is simply a diet containing such foods as milk, butter, eggs, meats, seafoods, bread, etc., supplemented by Haliver oil or carotene in oil, which is the purest form of vitamin A. Under any circumstances, the diet should not be prescribed until the patient has had a complete urological examination including a plain roentgenogram and pyelograms and cultures from both kidneys. The contents of the urine should be carefully studied with particular reference to the hydrogen ion concentration. If possible the total amount of calcium and phosphorus excreted in the 24 hour specimen of urine should be determined. If an excessive amount is excreted blood calcium and blood phosphorus determinations should be made. After these studies have been made a decision should be made as to whether the diet is indicated. If definite calculi are found in the roentgenogram, their position, size, consistency and distribution, together with whether the kidneys show infection, would be of paramount importance in considering the use of the diet.

It must be remembered also that the acid ash diet is of value only in those instances where the calculi are composed of the alkaline earthy salts, most commonly the phosphates. No claims have been made for the diet in the dissolution of any other types of stones in the human. Higgins has reported the dissolution of oxalic calculi in experimental animals by use of the alkaline ash foods and this diet should be used in cases of calculi where the urine is found to be highly acid.

If the indications for the diet are to be enumerated they are found to be comparatively few in number. Dietary management might be considered in the case of a non-obstructing calculus located in a calyx; in patients who refuse operation for one reason or another; in patients having stones in both kidneys with some debilitating disease where an operation would be dangerous; in patients suffering from the formation of calculi as a result of long confinement in bed following fractures and immobilization in plaster casts. One of the chief indications for the use of dietary treatment is in those patients who repeatedly have attacks of renal colic and pass small calculi, but who show no evidence of stones in the roentgenograms. The diet is likewise indicated in patients with alkaline encrustations in the bladder and in patients who show the deposition of areas of sand or gravel in the kidney parenchyma. Care must always be taken that the patient to whom the diet is given has an alkaline urine as only recently a patient was seen who had been using the diet in the presence of an acid urine. Such a measure was only accelerating the growth of the stone, as obviously this particular stone was developing in an acid urine. The high vitamin A acid ash diet is definitely contraindicated, in the opinion of most urologists, in all cases of calculi in the pelvis of the kidney, the ureter and in the bladder.

The danger to the patient of undergoing sudden obstruction of the ureter far overshadows any possible benefit that might arise from the diet. This extremely important contraindication leaves only a relatively small percentage of all patients suffering with stone in which the dietary treatment could be used. The diet has always the potential danger of producing acidosis and in patients susceptible to this condition should be very carefully supervised.

After considering these indications and contraindications of the use of the dietary treatment of urinary calculi, there are several very definite advantages in its use. It should be used in the treatment of those types of stones which have been previously enumerated whenever feasible and without danger to the patient. It should be used in the treatment of alkaline encrustations of the bladder. In acidifying the urine in the treatment of kidneys infected with organisms of the colon group, it is of great value. And lastly, the greatest and by far the most important use of the diet is as an aid in the prevention of formation of calculi after their surgical removal. Higgins claims to have reduced the incidence of recurrence of calculi following operation from

16.4% to 4.6% which is an indication of great benefit from the diet. This benefit, aside from the addition of vitamin A, is nothing more than the production and maintenance of an acid urine in those patients from whom alkaline stones were removed and the production of an alkaline urine where acid stones were removed.

Little or no mention has been made here of the use of the alkaline ash diet because of the fact that the so-called acid stones, namely, those formed of uric acid and the oxalates as well as cystine calculi are very rare, but before any type of diet is administered the stone removed should be chemically analyzed. This analysis can be easily made by the urologist or in a modern laboratory and it is also well to take cultures from the center of the stone in an effort to determine the presence of bacteria. It must be always borne in mind that the use of the diet postoperatively is but an adjunct in the treatment to prevent calculi recurring. Careful attention must be given the infection in the kidney which is almost always present. Pelvic lavage with antiseptics and particularly with mallic and phosphoric acids, as suggested by Keyser and Randall, is probably the most important measure that should be carried out.

In the use of the diet the patient must have means at his disposal for determining daily the hydrogen in concentration of the urine. In the majority of instances the diet itself is not capable of rendering the urine sufficiently acid and some supplementary acidifying drug may be necessary.

With all this information at our disposal the study of urinary calculi continues to be a most baffling problem. More than two years ago I removed a large phosphatic calculus from a kidney. As a postoperative means of prevention the high vitamin A acid ash diet was used alternating with the ketogenic diet and supplemented with acidifying drugs. The hydrogen ion concentration was kept well around 5.0. About one and one-half years later an infection developed and stones were found in both kidneys.

The writings on the subject of stones of over a hundred years ago, such as the long hand notes of Dr. Benjamin Rush discovered by Dr. Miley Wesson a few years ago, quite accurately describe our present problem. In one of his lectures at about the beginning of the Revolutionary War he extolled his listeners that, "the success of medicines in this disease depends upon their being used when there is apparently the least necessity."

SPANISH MOSS
(Dendropogon Usneoides)

FRANK C. METZGER, M.D.,
Tampa.

When I first started the practice of allergy in Florida, very little was known in regard to the local plants as factors in the causation of hay fever and asthma. True, the flora had been found and classified by various botanists, but there was no information available on the points of interest to an allergist, such as: pollination time, concentration of pollen in the air, and potency of these pollens in regard to their excitant content. Consequently, I had many puzzling cases and I was then, and still am, constantly looking for these undiscovered factors which might have a bearing on the problem.

The so-called "Spanish moss," due to its abundance and widespread distribution in Florida, was, of course, worthy of investigation. "Spanish moss" is a misnomer. It is not a moss, but a true flowering plant. Small classified it as a *Dendropogon Usneoides* of the family of *Bromeliaceae*. As far as is known, it is native to this land. A description of it is found in the Spanish histories of Florida, so, obviously, it was here when the Spaniards first came to these shores. It has an inconspicuous, small, yellow flower. These flowers are not numerous. They are present in the months of May and June, although a few may be seen in other months. In an endeavor to find out whether this plant played any part in the causation of hay fever, asthma, or contact dermatitis, I performed the following experiments:

I secured a number of these blooms, separated the pollen as well as I could, identified this pollen microscopically, and made a small amount of pollen extract. I then exposed slides in the following manner and places: A series of fourteen slides was exposed on the limb of a tree completely surrounded by the moss during its flowering period. Ten yards from the tree, a similar series was exposed, as was also another series in the window ledge of my home, fifty yards from the nearest bit

of moss. An occasional pollen granule, identified as coming from the bloom of the Spanish moss, was found on the slides encircled by the moss. The total number found on the fourteen slides exposed in this location was seven. On the series exposed ten yards from the moss, two pollen granules were found. On the series exposed on the window, ledge, none were found.

Selecting a group of thirty cases of asthma or hay fever, or both, whose history showed that their trouble was worst at this season of the year, I tested them with the extract obtained from the pollen of the Spanish moss. These tests were the usual scratch test, followed, if negative, by an intradermal test. One patient showed a definite positive to scratch test, and one showed a single positive intradermal test. Both of these patients showed positive tests to practically every pollen extract to which I tested them. I concluded, therefore, that these two cases were in that pollen sensitive group, who show to practically all pollen, and did not consider them as specificially sensitive to Spanish moss pollen alone.

The negative results obtained on the two series of slides exposed beyond a ten yard radius led me to the conclusion that this was not a wind pollenated plant, that it did not meet the postulate, that it produced pollen in large quantities; therefore, it was of no practical importance in the causation of hay fever or asthma from its pollen. The results obtained from the tests mentioned, while by no means conclusive, were considered as additional evidence in favor of the above conclusions.

Spanish moss is being used commercially more and more, chiefly as a filling for mattresses and pillows. When dried, the moss has a tendency to scale and form a light, powdery dust. The allergenic properties of certain ground up plant materials, notably orris root and Pyrethrum, are well known. The possibility arose, therefore, that the dust from the Spanish moss might act in a similar manner as the above mentioned plants. This possibility was investigated in the following manner:

A bunch of the moss was dried and the scaly, dry exterior plus a little fibre was extracted. Fifty patients were tested with this extract without obtaining a single positive test, which I considered of the specific variety.

Fifteen cases of contact dermatitis were patch tested with both the dry moss and the living moss. I put these tests on along with the routine patch tests, but did not obtain any positive results from the tests with the moss.

Conclusions: I was not able to demonstrate that Spanish moss was a causative factor in hay fever, asthma, or contact dermatitis, either from the pollen or from the dried material of the plant.

PEPTIC ULCER

(Report of 20 Cases of Perforation)

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Century.

Peptic ulcer is a condition frequently found; is perhaps over-diagnosed in some instances, and certainly underdiagnosed in many. It is a very serious condition because of its tendency to become chronic, and because of the many complications which may arise in its course: hemorrhage, obstruction, perforations with danger of localized and generalized peritonitis, subphrenic abscess, pancreatic inflammation, perforation into the thorax, gall bladder disease, etc.

The cause of peptic ulcer is not known. Several theories have been advanced from time to time, but all lack proof. The neurogenic, embolic and infectious theories are the most popular. It seems to me that these go out of the way to interpret something which could be explained more easily. Considering the rugosity of the interior of the stomach and intestines, it is really surprising that so few people have ulcers. It can be readily understood that small food particles and debris, once lodged therein, would be almost impossible of dislodgment. If these remain very long, irritation, inflammation and ulceration may easily take place.

In the case of the lesser curvature, this does not hold true. However, if one can observe peristalsis, it will be seen that this area is more fixed and the stomach contents are forced against it, as well as against the antrum and pylorus. The duodenum is more fixed than the stomach, and peristalsis cannot be vigorous; hence, it is more likely to retain irritating particles. Furthermore, it appears under the fluoroscope to be more of a

passive receptacle than an active organ. It is a curious fact, but nevertheless true, that the duodenum and rectum are more prone to lesions than the rest of the alimentary tract, with the exception of the mouth, and they are the most fixed organs.

The medical treatment of peptic ulcer is based on the elimination of irritating foods: alcohol, coffee, fried foods, course bulky foods, and recently, tobacco. These are harmful in two ways—mechanically and as excitors of gastric secretory activity.

Strumpell[1] states: "Gastric ulcer appears to be more frequent in women than in men, but if definite cases only are included, the difference in the sexes is not great." He also states that "duodenal ulcer is more frequent in males than in females."[2] Rivers,[3] in reviewing 2,499 cases of chronic gastric and duodenal ulcers, found that the duodenal ulcer is nine times as frequent as gastric; that it occurs three and one-half times more frequently in men than in women; and that men are five times more subject to duodenal ulcer than women. The usual age of the victims is from 25 to 50, but no age is immune. Medical men often do not see the ulcer in the acute stage and, in many instances, not until years after its onset. Most of the patients present themselves with the self diagnosis of "indigestion" or "catarrh of the stomach," both of which are almost meaningless. Many have been treated with irritating soups, broths, and fruit juices.

The characteristic symptoms of duodenal ulcer are: pain several hours after eating-relieved by taking of food; almost clock-like precision of the pain, food relief sequence: frequently a seasonal flare-up of ulcer, spring and fall being the seasons most often mentioned. These people are almost always taking soda. They often are awakened at night and have to take water or food or soda for relief. The symptoms of gastric ulcer are not so precise. They come on soon after eating and continue until the food is expelled, either by vomiting or by passing into the duodenum. Soda gives some relief. The food distress is much greater than in the duodenal ulcer. Therefore, food fear develops early and these patients usually lose weight, whereas the patient with duodenal ucler is often fat.

The usual complications have been mentioned, and only perforation will be discussed here. Perforation, particularly perforation with much soiling, is a real tragedy, and is reflected in the behavior of the victim. There is acute agonizing abdominal pain. The patient will often fall; certainly, he will not move far after the seizure. The intense pain is at first in the epigastrium, but gradually spreads downward, usually more to the right than to the left, and thus, is often diagnosed as appendicitis. The pain is so excruciating that it is difficult to obtain a history, for every movement, even talking, increases it. There is often pain about the neck, shoulders, and thorax if the diaphragm is soiled. The doctor is presented with a picture something like this: the patient is seen with pinched and anxious facies, groaning, but lying in a constrained position; respiration shallow; abdomen painful to the slightest touch, and of boardlike rigidity; and he may or may not have vomited. He is pleading for relief. The pulse and temperature at first show very little disturbance, and the laboratory findings are not of much help in the early hours and should not be depended upon. Confronted with this picture, almost anyone will recognize an acute surgical emergency and prompt action is necessary.

There are variations in the intensity of the symptoms. The brief description given is of the frankly soiled case. Slowly leaking perforations may cause very little discomfort and may go on to recovery without operation.

The treatment is obvious and consists of immediate operation with suture of the perforation, and cleaning the abdomen of the irritating material. A delay will give time for the development of peritonitis and then the operation will be useless, and merely hasten the death of the unfortunate. There are three main controlling factors in the outcome of the case, i.e., the amount and character of soiling, the length of time the soiling has existed, and the condition of the closed perforation—whether it is water tight. The question of drainage has not been settled. Personally, I drain the soiled area, particularly the lesser peritoneal cavity, and the kidney pouch on the right.

Roscoe Graham[4] in an editorial under the caption "The Surgeon's Debt to Fundamental Science" states: "The application of the above principles (meaning the use of saline, glucose, etc., intravenously and anti-shock measures

generally) to patients suffering from acute perforation of duodenal ulcer has permitted us to operate on 40 consecutive patients without a death. Sixteen of these patients required subsequent radical operation. None died from this secondary procedure." I am not so sure but that this was a streak of luck. I suspect that the result obtained was due more to an intelligent, referring group of physicians than to the preoperative treatment. Most of us today attempt to hydrate, put sugar in the blood, combat shock, etc., but any considerable loss of time with such measures is fraught with a grave danger, the development of generalized peritonitis. The very patients who most need the preoperative preparation are the ones who demand the earliest possible repair and cleansing. Many patients suffering from slowly leaking ulcers with little soiling would recover without operation, but no one can say when these ulcers will break through their barriers and flood the peritoneal cavity. Promptness of action is necessary in all cases, and preparation can be made while the operating room is being set up, and during the operation. Morphine and atropine are used freely in these operations. It should be remembered that the intestinal contents are what produce shock and spread bacteria which invade readily the damaged serous membrane.

I have charted 20 cases of perforation of which the following is a summary: The average age was 34.3 years—youngest 17 years, oldest 59 years; the average temperature was 100 degrees F.; pulse, 94; respiration, 28. The urine was normal in 11 cases, abnormal in three, and no record was secured in six. Blood pressure, systolic, averaged 127; diastolic 80; white blood corpuscles 12,849; red blood corpuscles 4,154,400; polymorphonuclears 82%; hemoglobin 75%. Sixteen of the patients were white and four colored. Pain was present in 100% of the cases. The duration of ulcer symptoms was three years or more in seven cases, from one to three months in two, and no history was obtained in 11. The duration of the perforation was from three to twenty-four hours in ten, from one to seven days in six, with no history in four. There was history of blood in the stool in one, none in nine, with no history in ten. Abdominal rigidity was observed in thirteen, tenderness in one, with no record for seven. Gas under diaphragm, three examinations, was positive once. Diagnosis, including alternate diagnosis, correct in 18 cases, wrong in 1, with no diagnosis made in 1, was as follows: duodenal ulcer 13, gastric ulcer 6, carcinoma 1; soiling extensive 14, small 6, localized peritonitis 7. Closure was made in most cases by purse string and Lembert's suture, with fastening the omentum over the sutured area, and in two cases fastening the gall bladder over the sutured area. Drainage was instituted in all cases, with the drain completely removed on the eighth day. Postoperative treatment consisted of morphine and atropine given freely for 48 hours, proctoclysis and hypodermoclysis and intravenous glucose. Bowels moved by enema in 42 hours as an average. Nourishment was first given on the fifth postoperative day with light food on the tenth. One patient had obstruction of the bowels on the ninth day from adhesions about the pelvic drain; also, he vomited a good deal prior to the obstruction. One patient returned to the hospital six days after his discharge with influenza and diaphragmatic pain which kept us in anxiety for a while because we feared subphrenic abscess. In these 20 cases, 13 patients (65%) recovered and seven died, a mortality of 35%. The average number of days of hospitalization for those who recovered was 24; wound infection for those who lived, 8; no infection, 1; no record, 4.

In presenting the 20 cases, I do not expect to prove or disprove anything, or draw any conclusions. They are presented to focus the discussion on the most dangerous complication of peptic ulcer. Even though the number is small, their analysis brings out the most salient points of this complication, namely, the amount of soiling, the time factor, operative procedure, and the end result. Also, it is hoped that their presentation may induce others to analyze their cases, and perhaps a large enough number may be accumulated to make a study from which conclusions can be drawn that will be worthwhile. The text books and current literature do not devote much space to a discussion of this condition.

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THE ENDOCRINE NEEDS OF THE PREMATURE INFANT*

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There is no literature so far as I have been able to find that deals with the endocrine deficiencies of the premature infant.

It is generally understood that the thyroid gland does not become active until the eighth month of intrauterine life, but there are no records that I have been able to obtain that approximate the date of intrauterine life when the other endocrine glands begin to function. For the sake of argument or for the lack of better information, we will assume that the other endocrine glands begin to function at about the same time of intrauterine life as the thyroid. Therefore, as a result of this logic, the child must receive its endocrine supply from its mother prior to the eighth month of intrauterine life.

As I have stated in a former article, it has been proved by therapeutic tests that children born to hypothyroid mothers are likewise hypothyroid and vice versa. This being true, the infant receives twice as much thyroid during the ninth month of intrauterine life as he does during any of the previous eight months. If the mother is hypothyroid, the infant therefore is necessarily born a hypothyroid. If this same infant should be a premature, say at six, seven, or even the eighth month, its chances for survival would necessarily be lessened due to a deficiency of the thyroid secretion from its mother. It is generally recognized that the thyroid gland is the key organ of the entire endocrine system, because when a patient is hypothyroid there is an accompanying deficiency of the internal secretion of the entire glandular system.

From the above facts it can be clearly stated that all premature infants have a deficiency of all the glands of internal secretion.

SYMPTOMS

Premature infants are exceedingly delicate, and many delicate infants born at full time require special attention. The viability of these children is so delicate, and unless their weight and height respectively exceed five pounds and nineteen inches, congenital feeble-mindedness or prematurity may be assumed. The organs of these infants are most likely to be poorly developed and they are not prepared to assume the role of life. Especially is this true of the lungs and digestive organs.

The clinical picture is characteristic. The baby is limp; the skin very soft and delicate and almost transparent; the cry a low feeble whine; the respiratory movements extremely irregular, sometimes scarcely perceptible for a few seconds; the movements of the extremities infrequent and never vigorous. The muscles of the mouth and tongue and cheek lack the requisite for sucking so that it is practically impossible, and even deglution is slow, difficult and prolonged. It is extremely difficult to maintain the normal body temperature; unless closely watched it may fall far below the normal, and may rise as much above normal with the use of too much heat. I once saw a fluctuation of 13 degrees F. occur in a few hours from such causes. The general appearance is one of torpor, such as you would find in any marked deficiency of thyroid even in a full time infant.

TREATMENT

The successful management of these cases depends on the degree of prematurity and the handling of three problems: maintenance of body temperature, nourishment, and the prevention of infection.

Past experience has taught that when a delivery is pending we must know if it is a premature delivery; if so, the room temperature is brought to around 80 degrees. The bed to receive the premature infant is warmed by hot water bottles and the premature jacket is made ready. At the time of delivery the infant is surrounded by hot wet towels, is immediately covered with warm olive oil and transferred to premature jacket, placed in bed, and placed in the premature ward where heat and air currents are controlled and the temperature of room kept at 80 or 90 degrees. Without these precautions, the mortality of premature infants is greatly increased. This is clinical proof beyond doubt that the premature infant is not capable of meeting the changed condition by readjustment and function of his own heat-producing organs of internal secretion, the adrenal and the thyroid glands. Under the above described condition, if the adrenals were capable of functioning, heat regulation in the premature would be adjusted the same as in the full term infant. The adrenal glands normally protect the body from sudden

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changes until the thyroid gland can come to the rescue, establish permanent heat regulation, and relieve the exhausted suprarenal gland as they do in the full term infant.

The function of the suprarenal and thyroid glands is absent in the premature which has been proved by clinical experience; hence artificial heat production and regulation are the only measures that have been used up to this time. In a few cases of premature infants I have used adrenaline (whole gland) and thyroid. The response in the more mature prematures has been very encouraging, but the dosage and best method of administration has not been well enough established to give out as being authentic. Dosage should be left to the judgment of attendant to work out for himself, based on the problem confronting him. In determining the dosage of thyroid and adrenal gland the development of the premature must be considered, because the poorer the powers of absorption the greater the dose in order to get the benefit of administration of endocrine products. It is best to begin with a small dose and gradually increase to a point of tolerance as would be done in any hypothyroid individual.

Milk which has been debufferized with some acid is best utilized, because the premature infant has a hypoacidity as well as a pancreatic deficiency. Insulin has not been used in my cases but its secretion should be considered as a factor in dealing with the premature.

Many of the premature infants have a large distended abdomen, dry and wrinkled skin, are dehydrated and present a characteristic senile appearance of entire body, subnormal temperature, etc., all of which point to a pluriglandular deficiency. All of these symptoms are present in the old time marantic child which always responded to acid diet, fluids and the administration of thyroid, adrenal, insulin, and glucose.

SUMMARY

It is not claimed that the theory advanced is a specific in prematurity but that the introduction of these aids is a sensible, practical procedure and is of definite value in treating premature infants. The premature infant does not lend himself well to laboratory study. Therapeutic tests supported by lessening of mortality and diminished morbidity are advances that can be termed useful.

THE PSYCHIATRIC PERSPECTIVE AS APPLIED TO GENERAL MEDICINE

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To us, today, living at the right-hand end of a graph that charts the advance of civilization, the dawn of creation must be considered not only the birth of a long history of phylogenetic changes as regards the evolution of the soma, but as the origin of those emotional drives which, collectively appreciated as the instincts and primordial motives of human behavior, have become the complexities of life as we know them now. There has forever been an inseparable correlation and integration of the dynamic changes in physical and mental mechanisms. That the great majority of personalities that comprise society at large demonstrate an adequate adaptation of mental to physical processes, and physical to mental processes, is alone sufficient evidence, I am sure, to bear out the truth that both the phylogenetic and ontogenetic evolutions of both the physical and mental qualities are proportionately progressive. The physique of our ancestors was certainly different from that of modern man, just as our mental processes today are different (and proportionately so) from those of our long-ago forebears. There is no divorcing the two, which, coupled, comprise the broad concept of personality. This term is used not as the identifying name for cultural refinement nor, in the tongue of contemporary modern diction, the so-called "it," —but personality as comprising the organism as a whole, the somatic, with its endocrine, voluntary and autonomic nervous systems, and the psychic, with its gross emotional and intellectual factors, are integrated in the presentation of an individual person. This personality is the thing which, when diseased, falls to the hands of the physician for correction. Medical practice, then, is the treatment of the person as a whole, rather than the disease process. The patient who consults his phsyician for any given illness presents a disorder in his general economy: physical or physiological, and his relations to the increasing complexities of modern living—constitutional, environmental, and emotional. To the psychobiological teachings of Adolf Meyer we are indebted for this pluralistic approach in the understanding and treatment of the patient as a whole so

that not only is our own intelligence not insulted in the management of human beings like ourselves who become ill, but so that the patient himself may receive a rational of treatment that results in a quicker and more lasting improvement. To the psychoanalytical teachings of Sigmund Freud we are indebted for the concepts of the universal mental mechanisms, some important ones of which are conflict, repression, sublimation and substitution, symbolization, identification, compensation and over-compensation, projection and introjection, regression, dissociation, etc.

There has evolved, in the last forty-odd years, an accepted working hypothesis of psychodynamics, or, better, physio-psychodynamics, which, even in that infancy, promises to be as scientifically basic in its applications as the long-ago accepted theory of atomic and electronic dynamics. There is a constant play between the major opposing forces in mental mechanisms, and an adequate understanding of the motivations of normal human behaviorisms is the essential armamentarium of the psychotherapist; and, conversely, that normal is intelligently appreciated through a study of the conventional abnormal, or insane.

To return, and couched in other words, the physician whose mental visual fields are not contracted by an ignorance of psychiatric understandings will consider always the kind of person who is his patient; he will have an intelligent and scientific insight into the emotional drives and environmental responsibilities of his patient; he will not only be able to tease the essentially psychoneurotic complaints from those that are demonstrably organically present, but will be able to evaluate in correct terms the total personality, the psychological as well as the physiological and chemical. His diagnostic acumen will be more sharp, and his therapeutic endeavors more greatly rewarded. Errors will be less frequent.

Now, there are primarily three kinds of patients: those who are overwhelmingly physically sick, those essentially mentally sick (irrespective of physiological sequelae), and those who are at the same time afflicted by both. In considering the first, who can deny the dynamic bombardments of a mental, or emotional sort that visit the patient ill with pneumonia, appendicitis, sinusitis, or whatnot? And just as undeniable is the need for a balance in that personal, human equation we choose to call the Art in Medicine, scientifically applied. Peptic ulcer, for example, is originally a psychogenic disease process, and the treatment of that disease process is certainly not limited to the administration of prescribed diets, antispasmodics, and alkalies. An appreciation of the results of psychic forces is of an importance that is paramount.

The patient who is judged as the "mental case" because there are no physical or chemical findings to explain the cause of his complaints, be he mildly psychoneurotic or obviously psychotic, must be guided with utmost care, precision, and patience. The weapons of psychotherapy must be chosen wisely and timed according to their effects. The too-often repeated gestures of dismission that accompany the unthinking physician's remarks of "There is nothing the matter with you: forget it: stop worrying: you're imagining things" not only result in a distressing discouragement in the patient, but are met with a resistance that makes a common-sense therapy that much more difficult. Particularly to be condemned is the fixation on given organs of delusions, such as occurs, for example, when a patient is told that his anal itching, which we assume to be essentially psychogenic, is due to a hypertrophied prostate which exists only in the mind of the examiner whose finger is untrained, and that that condition in general will be remedied by some kind of electrical treatment. While this kind of hokus-pokus smacks of charlatanism, and while it tends to deny the emancipation from superstition, prejudice, and ignorance of mental procedures that we are beginning to enjoy, it is, nevertheless, an example of an escape mechanism for the doctor, to say nothing of the patient, and is going on even in this 1937. It need only be mentioned that the patients falling in this group, like those anywhere in medical categories, should be given an exhaustive general examination first, and attempts be made to correlate mental maladjustments to such conditions, for instance, as the toxicities. Indefinite is the scope of discussion of this division; so, with a limited space, we shall proceed to the third general class.

The physiotherapy and chemotherapy of general paresis are well accepted procedures and definitely beneficial in about two-thirds of all cases. With a psychological perspective as

well, we must be equipped to treat the patient's behavior disturbances as well as the organic pathologic state, which requires an understanding of the factors concerned in psychopathology. There is an indisputable relationship between the organic ravages of the spirocheta pallida and the defects in memory, judgment, and emotional status. The peculiar syndrome that exists in each individual case depends on the life-conditioning of each individual person so affected: his personality make-up as peaked by the accumulation of a host of psychological experiences in his past. These must all be considered and therapeutic efforts directed toward them as well as the other, routine, treatments. This is but one example of the coexistence of organic and psychic difficulties. The number of instances is legion.

It might be well, here, to dilate somewhat on the factors concerning personality make-up, especially of value to the understanding of behavior in any patient. If we apply the term of "psychopathology of the normal," we assume, of course, that the mental mechanisms are universal, that they follow certain general laws, and that they are just as factually present in those we choose to call normal as in those who are mentally abnormal. This is true, indeed, and the margin of transition from normal to abnormal and vice versa is an indefinable one: so-called borderline states that tax the perspective of the consultant to extreme. A partial list† of topics concerned in investigating psychopathologic dynamics follows:

1. A patient ear to the uninterrupted complaints of the patient, and the conjuring of the multiplicity of possibilities.
2. The history of the present illness should include data on sleep, appetite, weight, medication, drugs, alcohol, compensation, and insurance.
3. The somatic history should stress accidents, operations, previous diseases, headaches, vision, diplopia, specks, gait, aphonia, paralysis, anesthesia, convulsions, tremor, dyspnea, palpitation; the gastro-enteric status, with emphasis on nausea, eructations, anorexia, and constipation; and the genito-urinary status, including menstruation and the sexual functions. Endurance and fatigue should be ascertained, and concern about body functions.
4. The physical examination must be exhaustive, particularly that of the relation of the general nervous system to other somatic functions, and the constitutional status.
5. In the personal history is the beginning of purely psychologic approach, some of the important items being previous attacks, hospitalizations, birth injuries, time of onset of walking and talking, school record, enuresis, spoiled-child tendencies, nightmares, stuttering, chorea, stealing or lying, legal difficulties, finances, work record, attitude toward relatives, sex questions, religion, disappointments, quarrels, responsibilities, accomplishments, ambitions, and hobbies.
6. The personality traits are learned by observation and outside history. The patient may be sensitive and shut-in, sociable and out-going, rigid, suspicious, moody, apprehensive, anxious, conscientious, abstract, eager to have sympathy, aggressive, etc.
7. The family history is important, of course, primarily because of identifications and formative environmental influences.
8. The topics of the mental status, aside from the general appearance and behavior, and the stream and character of talk, are almost entirely in the specialized field of the psychiatrist and psychologist, such as the large host of moods and special preoccupations; orientation, memory, judgment, calculation-ability, information, and insight.

Now, with these findings in hand, an interpretation of them in terms of reaction on the part of the patient is in order. If we consider life a succession of reactions of physical, chemical, emotional, and intellectual sorts, and if we appreciate the fact that as life progresses, so progresses also the complexities of civilized living, then we may realize that those reactions result in inevitable conflicts, primarily between unconscious drives on the one hand, comprising the vast amount of repressed emotional material that is commanding expression in one way or another, and, on the other hand, the coercive plays of conscience, social criticisms, et al. which, collectively, have become popularized as the super-ego. Here, we might

say, is the control of moods, that with the escape mechanisms result from the unresolved conflicts. Phylogenetic drives have ontogenetic expression, but in modernized living we must depend on sublimations and substitutions, for that expression, on compensation and overcompensation, symbolization, etc. Very important in shaping behavior is the influence of complex, which is a group of associated emotions that had been repressed into the unconscious, and is awaiting the necessary stimulus to give it an outlet, distorted as it may seem at the time. It is just as important to know that a usual means of defense is rationalization, or an attempt to explain in conscious terms of cause and effect the reasons for various feelings, wishes, or acts that are unconsciously directed. This is but a tangential presentation, because of time limitation, of the briefest number of psychologic reactions that are common to both the normal and abnormal; the discussion goes on indefinitely through the concepts of projection, introjection, phantasies, fixations, fugues, dissociation, etc.

It might not be amiss at this time to mention the importance of mental hygiene, which includes many of the principles of physical hygiene. It is the preventive of personality disorders, and conditions us to a strenuous life in order to dominate the stresses that are constantly pressing on us. From birth, through infancy and into childhood and adolescence, the most formative years of life are influenced by development, home atmosphere, general social environments, and, most important, adjustment to any situation, irrespective of difficulty. Mental hygiene in general connotes an appreciation of adaptation, a balance between the wishes and the "don'ts." It means the absence of that important dissociation between the affect and the intellect, with the physical economy the field of strain. Psychic-symptom-producing, and organic-symptom, accompanying, are such unhygienic factors as particular attachment to one parent, participation by the offspring in family criticisms of him, respect for temper tatrums, absence of commendation for constructive accomplishments, setting up other children in the family as examples, encouragement of "extra good child" feelings, discouragement of hobbies or talents, etc., circumstances with which we are either very familiar, or can easily learn. Mental hygiene is quite analogous to physical hygiene; in fact, it is a part of it, and as such can be practiced just as well. A little common sense is the greatest requisite.

So far as psychotherapy is concerned, the data that the physician has about the total personality of any given patient will permit him to make various recommendations, the most important of which may be environmental change, strict analysis, general re-education in the matters that are most disturbing, persuasion, assurance and re-assurance, suggestion, hypnosis, the attempt at an adequate sublimation of a primitive instinct, or prolonged hospitalization with occupational therapy, physiotherapy, hydrotherapy, etc., regardless of treatment directed toward the correction of a physical abnormality.

In the recent words of Foster Kennedy,[1] "Surely by its very nature . . . . psychiatry must pervade and be pervaded by all medicine . . . . surely the time has come to put away the notion that psychiatry deals just with mind-disease. . . . Our attitude is more a biopsychic approach than a mechanistic approach and is an effort not to be satisfied to explain the unknown by something equally unknown. We must believe that we cannot have intellect or ecstacy without a good neuronic endowment. The strategic outlines and boundaries of mind are laid down by physical heredity; its tactical plan by social inheritance, by education, and by the molding pressures of sex, the herd, and hunger. All may be destroyed by infection or degeneration."

Might I conclude here with a coupled plea, first, that an intelligent, biologic perspective be acquired by medical men in the guidance of their sick; and, second, that the darkness of ignorance, mysticism, and prejudice as it relates to psychiatry be illuminated by an insight into the Why of human behavior, so that a closer working harmony might be enjoyed between the doctors who do not understand or who will not take the time, on the one hand, and the psychiatric specialist, on the other hand.

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†Modified from Maurice Levine, Cincinnati, Ohio.

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Hewitt Johnston, M.D., "E," '40 ..... *Orlando*
Louie M. Limbaugh, M.D., "C," '39 ..... *Jacksonville*
Daniel A. McKinnon, M.D., "A," '40 ..... *Marianna*
Gerard Raap, M.D., "F," '38 ..... *Miami*

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Louis M. Orr, M.D., "E," '39 ..... *Orlando*
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Corbett E. Tumlin, M.D., "F," '38 ..... *Miami*

TUBERCULOSIS AND PUBLIC HEALTH

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Frederick J. Waas, M.D. ..... *Jacksonville*
Arthur L. Walters, M.D. ..... *Miami Beach*
Herman Watson, M.D. ..... *Lakeland*

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Homer L. Pearson, M.D., Alternate ..... *Miami*
(Terms expire after A.M.A. meeting, 1938)
Herbert L. Bryans, M.D., Delegate ..... *Pensacola*
Elliott M. Hendricks, M.D., Alternate ..... *Ft. Lauderdale*
(Terms expire after A.M.A. meeting, 1937)

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DISTRICT ANNUAL MEETINGS

One of the objectives this year of the Council is to have an annual meeting in each of the six committee districts. There are two councilor districts in each committee district and, with the cooperation of the secretaries, of the component societies the plan is working out exceptionally well.

The first annual district meeting was held in the Northwest Committee District (A) at Apalachicola, July 15. The results of this meeting will be found in this issue of the Journal. The second meeting will be held in the Southeast Committee District (F) at Miami, September 3. The program will be found in this issue of the Journal. The third meeting will be held in the Northeast Committee District (C) at St. Augustine, September 23. This program is also published in this number of the Journal. The fourth meeting will be held in the South Central Committee District (E) at Melbourne, October 21. The program for this meeting will appear in the September Journal. In addition to the publication in the Journal, individual programs will be mailed to each member in the district about ten days before the meeting is scheduled.

Your Council has been very active in arranging these meetings, which will make it possible for practically every member in the state to meet personally the officers of the Association during the year. This systematic arrangement of meetings in the districts is a service by your Council and state officers which, so far, seems to be highly appreciated by the members of the Association. The cities in the districts selected for the annual meetings have been centrally located and provide a minimum distance of travel for the members in the districts who attend the meetings.

NEW AND NONOFFICIAL REMEDIES 1937

The annual editions of "New and Nonofficial Remedies" contain all that the busy physician needs to know concerning the newer preparations which he is daily importuned by the detail men of the pharmaceutical manufacturers to use. The remedies listed and described here have been examined and found acceptable by the Council on Pharmacy and Chemistry, the deliberative body charged by the American Medical Association with the performance of this service for the practitioner, who has not the time or means to make the determinations for himself.

Some new drugs have been added in the 1937 edition, the descriptions of which will be found in the groupings to which they belong. There are some noteworthy changes in classification. The various vaso-constrictors, benzedrine, ephedrine, epinephrine and neosynephrin, have been grouped together as phenylalkylamine derivatives under the heading "Epinephrine and Related Preparations." This terminology is in keeping with the Council's policy of avoiding therapeutically suggestive names. Another similar change is the abandonment of the classification "Medicinal Foods" and substitution of a chapter under the title "Vitamins and Vitamin Preparations for Therapeutic and Prophylactic Use" in the previous edition. The consideration of other classes of food preparations was long ago transferred to the Council on Foods. The chapter "Organs of Animals" which has heretofore included only endocrine preparations has been expanded by transfers to this heading of the chapters Liver and Stomach Preparations, and Insulin.

RIDDING FLORIDA OF TUBERCULOSIS

The Woman's Auxiliary of the Florida Medical Association, with the cooperation of the Advisory Committee, at the beginning of the year, decided on a uniform program throughout the state to emphasize only one project. The purpose of this project is to aid in ridding our state of tuberculosis. The approach was made through an essay contest in each high school, with appropriate prizes for the winners. Prizes were awarded as follows: first prize, $25.00 in cash and the honor of broadcasting the essay; second prize, $15.00; third prize, $2.50. The essay contest was participated in by more than ten thousand pupils of junior and senior high schools in the state. Miss Harriet Griffith of St. Petersburg, Pinellas County, won first prize, for the best essay in the state. Miss Kathryn M. DuBose of Jacksonville, Duval County, won second prize and Miss Louessa Coghlan of Scanlon, Taylor County, won third prize. This contest has done much to promote health education in the state, which was one of the primary objectives.

TAX PROVISIONS OF SOCIAL SECURITY ACT

Operators of private laboratories, private sanitariums, and physicians employing one or more were advised recently by Commissioner of Internal Revenue Guy T. Helvering to make immediate tax returns as required under the provisions of Titles VIII and IX of the Social Security Act to avoid further payment of drastic penalties which are now accruing.

Commissioner Helvering pointed out that every person employed in such work came under the provisions of Title VIII, which imposes an income tax on the wages of every taxable individual and an excise tax on the payroll of every employer of one or more. This tax is payable monthly at the office of the Collector of Internal Revenue. The present rate for employer and employee alike is one per cent of the taxable wages paid and received.

Under Title IX of the Act, employers of eight or more persons must pay an excise tax on their annual pay roll. This tax went into effect on January 1, 1936, and tax payments were due from the employers, and the employers alone, at the office of the Collector of Internal Revenue on the first of this year. This tax is payable annually, although the employer may elect to pay it in regular quarterly installments.

The employer is held responsible for the collection of his employee's tax under Title VIII, the Commissioner explained, and is required to collect it when the wages are paid the employee, whether it be weekly or semi-monthly. Once the employer makes the one per cent deduction from the employee's pay, he becomes the custodian of Federal funds and must account for them to the Bureau of Internal Revenue.

This is done, Mr. Helvering said, when the employer makes out Treasury form SS-1, which, accompanied by the employee-employer tax, is filed during the month directly following the month in which the taxes were collected. All tax payments must be made at the office of the Collector of Internal Revenue in the district in which the employer's place of business is located.

Penalties for delinquencies are levied against the employer, not the employee, the Commissioner pointed out, and range from 5 per cent to 25 per cent of the tax due, depending on the period of delinquency. Criminal action may be taken against those who wilfully refuse to pay their taxes.

The employers of one or more are also required to file Treasury forms SS-2 and SS-2a. Both are informational forms and must be filed at Collectors' offices not later than July 31, covering the first six months of the year. After that they are to be filed at regular quarterly intervals. Form SS-2 will show all the taxable wages paid to all employees and SS-2a the taxable wages paid each employee.

Participation in a state unemployment compensation fund, approved by the Social Security Board, does not exempt employers from the excise tax under Title IX, Commissioner Helvering said. Nor does the fact that there is no state unemployment compensation fund relieve the employer of his Federal tax payments. In those states where an unemployment compensation fund has been approved, deductions up to 90 per cent of the Federal tax are allowed the employer who has already paid his state tax. These deductions are not allowed unless the state tax has been paid.

This tax is due in full from all employers

in states having no approved fund. The rate for 1936 was one per cent of the total annual pay roll containing eight or more employees, and for 1937 it is two per cent. The rate increases to three per cent in 1938 when it reaches its maximum. The annual returns are made on Treasury form 940.

An employer who employs eight or more persons on each of twenty calendar days during a calendar year, each day being in a different calendar week, is liable to the tax. The same persons do not have to be employed during that period, nor do the hours of employment have to be the same.

IMPORTANT FEATURES EMPHASIZED

Actual money, when paid as wages, is not the sole basis on which the tax is levied. Goods, clothing, lodging, if a part of compensation for services, are wages and a fair and reasonable value must be arrived at and become subject to the tax.

Commissions on sales, bonuses and premiums on insurance are wages and taxable.

Officers of corporations whether or not receiving compensation are considered employees for the purpose of taxation.

Wages paid during sick leave or vacation, or at dismissal are taxable.

Traveling expenses required by salesmen are not wages if the salesmen account for, by receipts or otherwise, their reasonable expenditures. That part for which no accounting is made is construed as a wage and is taxable.

Exercise great care in filling out Treasury forms SS-1 and 940. Directions are easy to follow and correct returns mean no unnecessary delay.

NORTHWEST DISTRICT ANNUAL MEETING

The first annual meeting of the Northwest Committee District (A) of the Florida Medical Association was held July 15, 1937, at Apalachicola. This was the first of a series of annual meetings to be held in the six committee districts of the state.

The attendance, enthusiasm and reception surpassed the highest hopes of those responsible for sponsoring district meetings. There was a total registration of 94. Of this number, 42 were members of the district; 8 were members of the Florida Medical Association residing outside this particular district; 19 were guests, representing non-member doctors and dentists; 25 were members of the Woman's Auxiliary and lady guests. Three past presidents were in attendance: Drs. Herbert Bryans, Pensacola; F. C. Moor, Tallahassee; and Henry E. Palmer, Tallahassee. A complete registration list is published below.

Dr. Augustus E. Conter acted as local chairman on arrangements and under his leadership the local groups were mobilized and distinguished themselves as hosts. The thoughtful preparation for the comfort and pleasure of the guests of this meeting has seldom, if ever, been surpassed. Electric fans were running in the assembly room continuously; ice water and cool drinks were conveniently placed; and the feast of seafood which was served by the ladies was typical of the extravagant advertisements from Apalachicola.

A number of long tables were erected on the large lawn adjoining the armory. Electric lights overhung each table. The shuckers kept oysters on the halfshell until all present had satisfied their appetites. The Apalachicola oysters are noted for their quality and the very choicest variety was selected for the guests of this meeting. Shrimp and fried fish, hot from the fires, were served up and down the tables continually. All of the trimmings that go with a fish fry were loaded on the tables by the charming ladies.

The program was unusually long, the weather hot, but this did not in any way interfere with the attendance at the sessions. Coats were taboo and the doctors, by their attention, indicated their real interest in the messages delivered. The meeting started at 3:30 in the afternoon and continued until dark.

Doctor Conter introduced Col. R. Don McLeod, city attorney, who welcomed the doctors and their guests. Dr. J. S. Turberville, senior councilor, then took the chair and after a brief outline of the purposes of the meeting, called on the following officers and committee chairmen who briefly outlined some of the activities of the Association: Dr. Edward Jelks, president of the Association; Dr. W. Henry Spiers, president-elect; Dr. Gilbert Osincup, chairman of the Executive Committee; Dr. W. McL. Shaw, chairman of the Council; Dr. N. A. Baltzell, junior councilor; Dr. Shaler Richardson, secretary-treasurer and editor of the Journal; and Stewart Thompson, managing director.

Doctor Turberville then turned the meeting over to Dr. N. A. Baltzell, junior councilor, who presided during the scientific session. Every essayist on the program was present and read his paper. The five papers presented were as follows:

"Appendicitis," Edward Jelks, Jacksonville; Discussion, Augustus E. Conter, Apalachicola.

"The Uses and Abuses of the Electrocardiograph," E. F. Wahl, Thomasville, Ga.

"Collapse Therapy in the Treatment of Pulmonary Tuberculosis," F. C. Moor, Tallahassee.

"X-ray Diagnosis," O. W. Britt, Chattahoochee.

"Malaria," Mark F. Boyd, Tallahassee.

REGISTRATION

Turberville, J. S., *Senior Councilor* ..... Century
Baltzell, N. A., *Junior Councilor* ..... Marianna
Thompson, Stewart, *Managing Director* ... Jacksonville

SECRETARIES OF SOCIETIES

Hoffman, J. M. ..... Pensacola
Miller, Allen H. ..... Millville
Pierce, J. L. ..... Marianna
Watson, F. M. ..... Chipley

GUEST SPEAKERS

Boyd, Mark F. ..... Tallahassee
Britt, O. W. ..... Chattahoochee
Jelks, Edward ..... Jacksonville
Moor, F. C. ..... Tallahassee
Richardson, Shaler ..... Jacksonville
Shaw, W. McL. ..... Jacksonville
Spiers, W. Henry ..... Orlando
Wahl, Ernest ..... Thomasville, Ga.

MEMBERS

Barnes, B. F. ..... River Junction
Bird, Terry ..... Greensboro
Brevard, E. M. ..... Tallahassee
Brown, G. W. ..... Tallahassee
Burns, M. Q. ..... Blountstown
Bryans, Herbert L. ..... Pensacola
Conter, Augustus E. ..... Apalachicola
Daves, F. E. ..... Chattahoochee
Dozier, L. L. ..... Tallahassee
Dykes, Chapman ..... Carrabelle
Gainey, J. G. ..... Blountstown
Godard, R. F. ..... Quincy
Griffin, Taylor W. ..... Quincy
Holland, Francis T. ..... Tallahassee
Huskey, Aubrey L. ..... Chattahoochee
Jenkins, O. W. ..... Chattahoochee
Johnston, J. K. ..... Tallahassee
Lischkoff, M. A. ..... Pensacola
McKinnon, D. A. ..... Marianna
McMurray, J. W. ..... Apalachicola
Massey, Wm. W. ..... Quincy
Miles, W. G. ..... Chattahoochee
Miller, R. L. ..... Graceville
Nixon, J. M. ..... Panama City
Palmer, H. E. ..... Tallahassee
Pickett, Wm. H. ..... Pensacola
Pound, J. H. ..... Tallahassee
Roberts, W. C. ..... Panama City
Robertson, J. C. ..... Chattahoochee
Rogers, W. D. ..... Chattahoochee
Sapp, J. W. ..... Havana
Segrest, R. H. ..... Bonifay
Stevens, Ralph E. ..... Chattahoochee
Whitaker, C. D. ..... Marianna
Whitfield, J. M. ..... Panama City

GUESTS FROM F. M. A.

Holloway, Luther W. ..... Jacksonville
Osincup, G. S. ..... Orlando
Robinson, Leigh F. ..... Ft. Lauderdale

VISITORS

Ausley, C. M. ..... Tallahassee
Bruce, J. G. ..... Apalachicola
Douglas, F. F. ..... Chattahoochee
Galin, Jack ..... Tallahassee
Garmany, G. H. ..... Chattahoochee
Ham, A. S. ..... Apalachicola
Harper, J. A. ..... Crawfordville
Kitchen, S. F. ..... Tallahassee
Meade, G. E. ..... Chattahoochee
Morgan, R. E. ..... Chattahoochee
Schultz, John M. ..... Chattahoochee
Steely, J. A. ..... Apalachicola
Stubbins, R. P. ..... Chattahoochee
Therrell, J. H. ..... Chattahoochee
Waering, K. K. ..... Quincy
Weems, G. E. ..... Apalachicola

WOMAN'S AUXILIARY—Members and Guests

Baltzell, Mrs. N. A. ..... Marianna
Bence, Mrs. A. E. ..... Wichita, Kans.
Bowen, Mary L. ..... Tallahassee
Boyd, Mrs. Mark F. ..... Tallahassee
Britt, Mrs. O. W. ..... Chattahoochee
Brown, Mrs. G. W. ..... Tallahassee
Corbin, Katherine L. ..... Bristol
Craig, Josephine ..... Tallahassee
Dozier, Mrs. L. L. ..... Tallahassee
Griffin, Mrs. Taylor W. ..... Quincy
Harper, Mrs. J. A. ..... Crawfordville
Holland, Mrs. F. T. ..... Tallahassee
Kincaid, Louise ..... Apalachicola
Massey, Mrs. W. W. ..... Quincy
Mathison, Enid ..... Port St. Joe
Pierce, Mrs. Lewis ..... Marianna
Pound, Mrs. J. H. ..... Tallahassee
Robertson, Mrs. J. C. ..... Chattahoochee
Sapp, Mrs. J. W. ..... Havana
Segrest, Mrs. R. H. ..... Bonifay
Stevens, Mrs. Ralph E. ..... Chattahoochee
Therrell, Mrs. J. H. ..... Chattahoochee
Watson, Mrs. F. M. ..... Chipley
Whitaker, Mrs. C. D. ..... Marianna
Whitfield, Mrs. J. M. ..... Panama City

STATE NEWS ITEMS

Dr. J. C. Pate of Tampa was recently made a Fellow of the International College of Surgeons at their meeting in New York City.

* * *

Dr. C. A. Fort, Jr., of Ocala, who recently completed a year's internship at the Tampa Municipal Hospital, has joined the Staff of the Florida State Hospital.

* * *

Dr. and Mrs. J. R. Sory of Lake Worth have returned from a vacation trip of six weeks during which they visited in Canada, the Carolinas, and with relatives in Tennessee.

Melbourne's new $45,000 Brevard Hospital was dedicated Friday afternoon, May 28. The mayor of Melbourne declared this day a legal holiday and stated in his proclamation that the completion of the Brevard Hospital was another milestone in the onward progress of the city of Melbourne. He declared the occasion of such importance as should command the interest and attention of all of the citizens of the city.

Many doctors from over the State assembled Wednesday to inspect the institution. The visiting doctors were honored at a banquet at the Woman's Club following the inspection of the hospital. Dr. W. C. Page of Cocoa, president of the Brevard County Medical Society, introduced Dr. I. M. Hay of Melbourne who acted as toastmaster. The toastmaster presented Dr. W. Henry Spiers of Orlando, president-elect of the Florida Medical Association, who praised the new hospital. He then introduced some of the other visiting doctors. Dr. Leland F. Carlton of Tampa, chairman of the Hospital Committee of the Florida Medical Association, spoke on the standards on which hospitals should be based; Dr. M. Jay Flipse of Miami, chairman of the Association's committee on Tuberculosis and Public Health, gave a very forceful talk and emphasized the advantages of a physical property as indicated by the new hospital to permit excellent work on the part of local doctors; Dr. Gilbert Osincup of Orlando, chairman of the Executive Committee of the State Association mentioned that a hospital is a great credit to the community; Dr. W. A. Weed of Orlando, commented upon the x-ray apparatus in the new hospital and congratulated the medical staff on having such splendid equipment; Dr. L. C. Ingram of Orlando, president of the medical staff of the Orange General Hospital, added his congratulations.

At the dedicatory program, Friday, Dr. W. J. Creel of Eau Gallie welcomed the out-of-town guests and visiting doctors. Dr. I. M. Hay is chief of the medical staff; the doctors associated with him are Drs. I. F. Bean and W. J. Creel.

* * *

Dr. Will L. Wood of Mount Dora is taking a postgraduate course in radiology at the Cook County Hospital in Chicago.

Dr. Lloyd J. Netto of West Palm Beach accompanied his family to Jacksonville on Sunday, July 25, from where they proceeded by car to Nashville, Tenn., for a visit. Doctor Netto returned to West Palm Beach by Eastern Air Lines.

* * *

Dr. O. C. Brown of Ft. Lauderdale is enjoying a six weeks' vacation in the North. Doctor Brown, on his trip, will visit clinics in Chicago, but will spend most of the time with relatives in Illinois and Indiana.

* * *

The next annual inactive duty training period for medical reserve officers of the Army and Navy will be held in Rochester, Minnesota at the Mayo Clinic under the military supervision of the Surgeon of the Seventh Corps Area (Army) and the Surgeon of the Ninth Naval District (Navy) from October 3 to 16, 1937. The meeting is given for reserve officers of the Army and the Navy and due military credits are given for attendance.

Applications should be submitted to the Surgeon of the Seventh Corps Area, Omaha, Nebraska or to the Surgeon of the Ninth Naval District, Great Lakes, Illinois. Enrollment is limited to 200. The Surgeons General of the Army and Navy have signified that they will attend and it is believed that the Surgeon General of the Public Health Service will appear on the program also.

* * *

Dr. V. M. Johnson, pathologist at the Good Samaritan Hospital, West Palm Beach, and Miss Lois McCartney were married on June 1. They are at home at 518 31st Street. Mrs. Johnson was formerly chief technician at the Good Samaritan Hospital.

* * *

On Thursday evening, July 8, a guest program was put on by the staff of the Riverside Hospital in Jacksonville. Forty members and guests were in attendance and a very pleasant evening was enjoyed. The following scientific program was presented:

"Intestinal Obstruction in Children"—T. H. Bates, Lake City.

"Diagnosis and Treatment of Athletic Injuries"—Fred Mathers, Gainesville.

"Anomalies of Intestinal Rotation with Review of the Embryological Development and Report of a Case"—Hugh West, DeLand.

A new wing which has just been erected as an addition to the Riverside Hospital is practically completed. A number of the new offices for the staff are now occupied and the balance of the space will be in working order as soon as some additional equipment has been received. This new addition to the hospital is very attractive, affords more light, includes a spacious waiting room, and will better enable the institution to care for its increasing number of patients.

* * *

Dr. G. C. Hardie of Ft. Pierce spent a month's vacation recently through the Carolinas. He spent most of the time at Waynesville.

AUGUSTUS B. CANNON

The untimely death of Dr. Augustus B. Cannon, which occurred in Ridgeland, South Carolina on May 25, took from the ranks of the Florida Medical Association one of its outstanding members.

Doctor Cannon was born July 15, 1870, at Whitehall, S. C. After graduating from Marion-Sims College of Medicine, St. Louis, Doctor Cannon moved to Florida where he practiced medicine for thirty-eight years. He was located at Lacoochee for fourteen years prior to his retirement in January, 1937, when he moved to his home in Ridgeland, South Carolina.

He was a charter member and past president of the Pasco-Hernando-Citrus County Medical Society, member of the Florida Medical Association and the American Medical Association, member of the Mystic Order of the Shrine and other fraternal organizations.

Doctor Cannon keenly kept abreast of modern medical knowledge and took frequent postgraduate courses in several medical centers of this country. He has reflected honor on the medical profession and his studious habits gained for him many friends.

Doctor Cannon is survived by his wife, Mrs. A. B. Cannon, of Ridgeland, S. C.

The Chattahoochee Valley Medical Association held its Thirty-seventh Annual Session at Radium Springs, Albany, Georgia, July 13-14, 1937. Many members of the Florida Medical Association were in attendance—several as officers of the organization: Dr. C. E. Royce of Jacksonville, second vice-president; Drs. J. C. Davis of Quincy and Edward Jelks of Jacksonville, members of the Council.

Space will not permit the publication of the entire program as it was very long. Papers presented by Florida doctors were as follows:

"A Case of Typhoid Fever," Clayton E. Royce, Jacksonville.

"Primary Psoas Abscess" (lantern slides) Herbert E. White, St. Augustine.

"Peri-Nephritic Abscess" (lantern slides and motion pictures), Robert B. McIver, Jacksonville.

"Color Movie and Lantern Slide Demonstration of the Results of the Treatment of Cancer with X-ray Radiation", H. B. McEuen, Jacksonville.

"Surgical Treatment of Pulmonary Tuberculosis" (lantern slides and motion pictures), Kenneth A. Morris, Jacksonville.

"The Premature Infant," Luther W. Holloway, Jacksonville.

"The Use of the Flexible Gastroscope," James L. Borland, Jacksonville.

Florida doctors who discussed papers were: Dr. Louie M. Limbaugh, Jacksonville, discussed paper by Dr. Herbert Caldwell of Tuscaloosa, Ala., on "Some Unusual Electrocardiograms"; Dr. Louis Orr of Orlando discussed "Medical Treatments of Urinary Infections" by Dr. Wallace L. Bazemore of Macon, Ga.

The doctors from Florida brought back very enthusiastic reports of the fine meeting which comprised the Thirty-seventh Annual Session of the Chattahoochee Valley Medical Association.

* * *

Dr. G. C. Bottari of Tampa left for Europe on July 31. After visiting his alma mater, the Royal University of Naples, he will attend clinics in Germany and France. Dr. Bottari will return to Tampa this fall.

* * *

Dr. J. C. Robertson, clinical director, Florida State Hospital, Chattahoochee, recently spent a week in Atlanta, combining business with pleasure.

Dr. J. B. O'Connor, who has just completed two years' internship at the Duval County Hospital, has joined the Staff of the Florida State Hospital at Chattahoochee.

* * *

Dr. and Mrs. E. W. Bitzer of Tampa are spending three months in Europe. During much of this time, Doctor Bitzer will study in Vienna. They expect to return in October.

* * *

Dr. Terry Bird's new address is Co. 4453, CCC, Greensboro, Florida. Doctor Bird is a member of the Bay County Medical Society.

* * *

Dr. George A. Dame and family of Inverness recently returned from an extended vacation trip. Senator Dame and his family visited in Virginia, Maryland and Delaware, touring up the East Coast.

This was a very fine opportunity for Senator Dame to recuperate from his strenuous work during the legislature. The splendid work of Senator Dame in connection with the medical bills was very much appreciated by the members of the Florida Medical Association.

* * *

Dr. N. P. Myers' new address is 702 Ninth Street, Bradenton. Doctor Myers' office is now located at his new address.

* * *

Dr. J. Lloyd Massey and Miss Mary McGeehee Wyatt of Birmingham, Ala. were married June 30, 1937, in Birmingham. Doctor Massey will be associated in practice with his father, Dr. W. W. Massey in Quincy. He took his premedical work at the University of Florida, his medical degree at Tulane, and his internship at the Hillman Hospital in Birmingham. Dr. and Mrs. W. W. Massey attended the wedding of their son.

* * *

Three members of the Florida Medical Association were on the program of the district meeting of the Southwestern Division of the Alabama State Medical Association held at Monroeville, July 21, 1937. Doctor Herbert Bryans of Pensacola and Dr. J. S. Turberville of Century presented a joint paper on "The Medical and Surgical Aspects of Thyroid Diseases;" Dr. J. M. Hoffman of Pensacola presented a paper on "Sterility in the Female."

Dr. John L. Jennings, Jr. of Boca Grande is spending the months of July and August with his father, Dr. J. L. Jennings, Sr. in Danville, Virginia.

* * *

The next meeting of the Florida East Coast Medical Society will be held in Hollywood, November 12 and 13, at the Hollywood Beach Hotel. Dr. E. C. Swift of Jacksonville is in charge of the program for this meeting.

* * *

The Florida Section of the Southeastern Surgical Congress will hold its annual clinical session at Tampa, Saturday, August 28. The meeting will be held at the Tampa Municipal Hospital, beginning at 9 a. m. Lunch will be served at the hospital at 1 p. m., and the discussions resumed after lunch until adjournment at 4 o'clock.

These clinics have been very successful in the past. There are no set papers. Clinical cases are presented and discussed by invited speakers, followed by open discussion from the floor. Among those who have been invited to discuss the cases presented are Drs. Frank Boland, Atlanta; Gilbert Douglas and D. O. Donald, Birmingham; and J. W. Reeves, Mobile. It is expected that Dr. Alfred Walker of Birmingham will also be present to discuss certain pediatric problems from the surgical standpoint.

The committee in charge of this clinic is composed of Drs. J. S. Turberville, Century; Leland Carlton, Tampa; and Frank D. Gray of Orlando.

All members of the Florida Medical Association are cordially invited to be present and to partake in the discussion.

* * *

Dr. M. A. Lischkoff and Dr. Herbert Bryans of Pensacola attended the executive committee meeting of the Gulf Coast Clinical Society at Gulfport, Mississippi, on July 11. Final arrangements were made for the next annual meeting to be held at Biloxi, Miss. on November 3 and 4, 1937. The membership of the Gulf Coast Clinical Society is composed of doctors residing in the gulf section of Florida, Alabama and Mississippi, with one annual meeting in the early fall, alternating in the three states.

Dr. Hollis C. Ingram returned to his home in Orlando recently, after an absence of twelve years in school and special training. He will be associated with his father, Dr. L. C. Ingram, in eye, ear, nose and throat practice.

* * *

IMPORTANT NOTICE TO DOCTORS

What kind of doctor are you? The public now has a legal right to know. Words or abbreviations clearly denoting the particular kind or branch of the medical or healing arts must appear in a conspicuous place at the entrance of your office or usual place of business. The lettering must be at least TWO AND ONE-HALF INCHES IN HEIGHT and ONE INCH IN WIDTH. Doctors are urged to see that they qualify without delay.

A complete reproduction of the new law follows:

SENATE BILL NO. 154

A BILL TO BE ENTITLED

AN ACT TO REQUIRE PRACTITIONERS OF EVERY KIND OR BRANCH OF MEDICAL AND/OR MATERIAL HEALING ARTS TO PLACE AND KEEP AT THE ENTRANCES OF THEIR OFFICES OR USUAL PLACES OF BUSINESS WORDS OR PROPER ABBREVIATIONS DENOTING THE PARTICULAR KIND OR BRANCH OF THE MEDICAL AND/OR MATERIAL HEALING ART THEY ARE LICENSED TO PRACTICE.

Be It Enacted by the Legislature of the State of Florida:

SECTION 1. Every person licensed under the laws of the State of Florida to practice medicine, surgery, osteopathic medicine, chiropractic, naturopathy, chiropody, pediatry or any other kind or branch of the medical and/or material healing art, whenever actively engaged in the practice of same, or whenever holding himself or herself out as a practitioner of same, shall cause to be placed and kept in a conspicuous place at each entrance to his or her office or usual place of business, words or proper abbreviations, in intelligible lettering not less than two and one-half inches in height and one inch in width clearly denoting the particular kind or branch of the medical and/or material healing art he or she is licensed to practice under the laws of the State of Florida.

SECTION 2. Any person convicted of a violation of this chapter shall be punished by a fine of not more than one hundred dollars or by imprisonment in the county jail for a period of not more than six months or by both such fine and imprisonment.

SECTION 3. All laws and parts of laws in conflict herewith are hereby repealed insofar as they conflict with this act.

SECTION 4. This act shall take effect immediately upon its passage and approval by the Governor, or upon its becoming a law without such approval.

Signed by the Governor May 25, 1937.

* * * * * *

Dr. D. Paul Bird of Lakeland and Miss Mildred Elaine Lewis were married on April 17 at Bartow.

* * *

Dr. and Mrs. P. H. Guinand of Clearwater spent most of the month of July touring through Mexico.

* * *

Dr. S. A. Hawkins of Clermont died on July 22, at the age of 82. Interment was at Claremore, Oklahoma.

* * *

Dr. A. L. Huskey of Chattahoochee recently returned from Elgin, Ill. where he completed a course in Insulin Shock Therapy under Doctor Heilbrunn, who was associated with Doctor Sakel.

* * *

Dr. J. C. Pate of Tampa expects to leave September 1 for New York, Boston, and Montreal, Canada, to visit surgical clinics during the month.

* * *

Dr. H. D. Clark of Ft. Pierce was a visitor in New York City recently. His daughter, who has been going to school there, returned home with her father.

* * *

ERRATUM

The name of Dr. J. I. Turberville of Century should have appeared on page 57 of the July Journal in place of that of Dr. J. S. Turberville. The broadcast on "The Responsibility of the Laity to the Indigent" was prepared by Dr. J. I. Turberville.

DISTRICT MEETINGS

The first annual meeting of the Southeast Committee District (F) will be held at Miami, Friday, September 3 at 6 p. m. in the Columbus Hotel. All members of the Florida Medical Association residing in this district are urged to attend. The officers of the Florida Medical Association have arranged to attend this meeting and you will, therefore, have an opportunity to meet and hear them. The annual meeting in this district is sponsored by the councilors with the cooperation of the secretaries of the component societies and they have arranged the following program:

SOUTHEAST DISTRICT (F)

F. K. Herpel, *Senior Councilor*
H. A. Walker,, *Junior Councilor*
Stewart Thompson, *Managing Director*

SECRETARIES OF SOCIETIES

Oliver C. Brown.....Ft. Lauderdale
Walter C. Jones.....Miami
Lloyd J. Netto.....West Palm Beach
William R. Warren.....Key West

LOCAL COMMITTEE ON ARRANGEMENTS

H. A. Walker, *Chairman*
Reuben N. Burch
Walter C. Jones
Scheffel Wright

FIRST GENERAL SESSION

FRIDAY, SEPTEMBER 3, 6 p. m.
COLUMBUS HOTEL

Call to Order—
F. K. Herpel, *Senior Councilor*
Address of Welcome—
Reuben N. Burch, *President*, Dade County Medical Society
Brief Addresses by State Officers—
Edward Jelks, *President*
Reuben N. Burch, *First Vice-President*
Shaler Richardson, *Sec'y-Treas.-Editor*
Recognition of
Committee Chairmen
Past Presidents
Selection of Meeting Place and Date, 1938
Announcements

SCIENTIFIC SESSION

Presiding, H. A. Walker, *Junior Councilor*

8:00 p. m.—"Ectopic Pregnancy"
Lloyd J. Netto, West Palm Beach
8:15 p. m.—Discussion
8:30 p. m.—"Resume of Fever Therapy"
Kenneth Phillips, Miami
8:45 p. m.—Discussion
9:00 p. m.—"The Treatment of Retinal Detachment"
Shaler Richardson, Jacksonville
9:15 p. m.—Discussion
Adjournment—

The first annual meeting of the Northeast Committee District (C) will be held at St. Augustine, Thursday afternoon, September 23 at the Munson Hotel. All members of the Florida Medical Association residing in this district are urged to attend. The officers of the Florida Medical Association have arranged to attend this meeting and you will, therefore, have an opportunity to meet and hear them. The annual meeting in this district is sponsored by the councilors with the cooperation of the secretaries of the component societies and they have arranged the following program:

NORTHEAST DISTRICT (C)

Hugh West, *Senior Councilor*
W. McL. Shaw, *Junior Councilor*
Stewart Thompson, *Managing Director*

SECRETARIES OF SOCIETIES

F. Emory Bell.....Palatka
George W. Croft.....Jacksonville
R. D. Harris.....St. Augustine
R. L. Miller.....Daytona Beach

LOCAL COMMITTEE ON ARRANGEMENTS

Charles C. Grace, *Chairman*
R. D. Harris
Herbert E. White

FIRST GENERAL SESSION

THURSDAY, SEPTEMBER 23, 3 p. m.
MUNSON HOTEL

Call to Order—
Hugh West, *Senior Councilor*
Address of Welcome—
Charles C. Grace, *President* St. Johns County Medical Society
Brief Addresses by State Officers—
Edward Jelks, *President*
W. Henry Spiers, *President-elect*
Shaler Richardson, *Sec'y-Treas.-Editor*
W. McL. Shaw, *Chairman of Council*
Recognition of
Committee Chairmen
Past Presidents
Selection of Meeting Place and Date, 1938
Announcements

SCIENTIFIC SESSION

Presiding, W. McL. Shaw, *Junior Councilor*

4:30 p. m.—"Some Complications of Labor"
S. R. Norris, Jacksonville
4:45 p. m.—Discussion
5:00 p. m.—"Congenital Osseous Syphilis"
Thomas M. Palmer, Jacksonville
5:15 p. m.—Discussion
5:30 p. m.—"Anomalies of Intestinal Rotation and Report of a Case"
Hugh West, DeLand
5:45 p. m.—Discussion
Adjournment

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

At the regular meeting of the Dade County Medical Society, held July 2, the following resolution was passed:

WHEREAS, it has come to our attention that there was submitted to the House of Delegates of the American Medical Association at Atlantic City, June 7 to 10, 1937, a contemplated plan by the Federal, Executive, Administrative and Congressional authorities to place the practice of medicine in the United States, as it involves the medical care of the indigent persons, under Federal Government control, and

WHEREAS, the Dade County Medical Association affirms its willingness to cooperate at all times with the proper local authorities in order to secure and administer adequate medical care to all indigent persons, and

WHEREAS, the Dade County Medical Association is convinced that such care is distinctly a responsibility of the local community through the city and county hospitals and various units for administering such care, and

WHEREAS, Federal supervision of the medical care of the indigent, without control of the local component medical units of the various State and local Medical Societies, will destroy those principles which maintain for the public the highest quality of medical service and will impede the possibility of improvement in this service,

THEREFORE, BE IT RESOLVED, that the Dade County Medical Association in justice to the medical profession, local, State and national, hereby records its absolute opposition to such a plan and its absolute unwillingness to cooperate in any plan that involves Federal supervision and control of the medical practice, local, State and national and will take every means at its command to combat this plan.

FURTHER, BE IT RESOLVED, that a copy of these resolutions be forwarded to our Senators and Representatives in Washington, D. C., also to the Florida Medical Association and to the American Medical Association, and also to the Press.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

THE PASCO - HERNANDO - CITRUS COUNTY MEDICAL SOCIETY HAS JOINED THE EVER-GROWING RANKS OF 100% PAID SOCIETIES. THIS SOCIETY IS HEADED BY DRS. W. WARDLAW JONES OF DADE CITY, PRESIDENT; S. C. HARVARD OF BROOKSVILLE, AND GEORGE A. DAME OF INVERNESS, VICE-PRESIDENTS; AND G. R. CREEKMORE OF BROOKSVILLE, SECRETARY-TREASURER.

PINELLAS COUNTY MEDICAL SOCIETY

On July 2, the members of the Pinellas County Medical Society and ladies enjoyed a social meeting at the Pass-a-Grille Beach Hotel. On the evening of August 6, they held an informal dinner and dance at the Lakewood Club.

ABSTRACT DEPARTMENT

KENNETH A. MORRIS, M.D., ABSTRACT EDITOR

Lupus Vulgaris in the Far South—FRENCH, ELMO D. and LEFHOLZ, Rothwell, Miami, *Southern Medical Journal*, Vol. 30, No. 3, 270 (March) 1937.

According to the authors, no case of lupus vulgaris originating in the State of Florida has ever been reported. Other forms of cutaneous tuberculosis have been observed. "The influence of climate upon the incidence of tuberculosis of the skin is generally recognized." A case is reported of multiple lupus vulgaris which was brought into the Miami area of Florida with a positive proof of the diagnosis by animal inoculations of the diseased tissue. The authors believe that "observations upon the course of the disease in an environment unfavorable to cutaneous tuberculosis would prove of interest." The case presented adapted itself particularly well to heliotherapy. Tuberculinotherapy is also emphasized. The comments were made upon the general and local effects of heliotherapy and the favorable course of the disease is described.

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A New Method For Opening a Carbuncle—Charles B. Mabry, Jacksonville, *Journal of the A. M. A.*, Vol. 108, No. 16, 1339 (April 17) 1937.

In the words of the author: "A furuncle hurts. It hurts because the tension caused by forces combating the infection together with the infection form a firm, hard mass which presses on hypersensitive nerves." A new method is described for opening a carbuncle. Freezing the furuncle or carbuncle with ethyl chloride before incision accomplishes little anesthesia because it is only a few millimeters deep. Also freezing makes the skin tough so that additional pressure on the knife causes extreme pain. The furuncle is frozen in the usual manner and a towel clamp is used to grasp the frozen skin and lift it up and away from the body. "The inward pressure of the knife becomes a balancing or counteractive force against the towel hook." It also prevents deep presure on the hard, inflamed hypersensitive tumor and limits the pain, chiefly because pain is always caused by pressure with the knife on the indurated mass.

Sickle Cell Anemia With Pregnancy—Lewis, Albert W., Jr., St. Augustine, Florida—*A. J. of Obstetrics & Gynecology*, Vol. 33, No. 4, 667 (April) 1937.

A case of sickle cell anemia is reported in a negro woman, twenty-five years of age. She was about three months pregnant. As a child she was troubled with fatigue and shortness of breath, and she was supposed to have had heart disease when ten years old. Three previous pregnancies had terminated in abortions at four to seven months. Her chief complaint at this time was shortness of breath and palpitation of the heart. Although well developed, she was undernourished, and her face appeared puffy. The mucous membranes were extremely pale. The uterus was palpable 5 cm. above the pubis. Laboratory findings: hemoglobin 45 per cent; R. B. C. 1,500,000; leukocytes 36,800; neutrophils 80 per cent; many sickle cells. Anisocytosis and poikilocytosis were present. Preparation for sickling revealed about 50 per cent sickle cells. The Wassermann reaction was negative. Gastric analysis showed no free hydrochloric acid. X-ray of the heart showed definite enlargement and x-ray of the left hand and foot revealed mottled areas of decreased density in the ends of the metacarpals, the metatarsals and the phalanges. X-ray films of the skull showed mottled areas of decreased density throughout, but chiefly in the parietal and frontal regions. No compatible donor could be found when cross-matching was done. Transfusions were not given. Pregnancy was terminated, and the patient was sterilized. The author points out that this case exemplifies the common error of mistaking sickle cell anemia for rheumatic heart disease. He suggests sickle cell anemia as a possible cause of abortions and considers pregnancy as a factor in exacerbations. The author believes that sickle cell anemia with pregnancy is rare, and that this case is the fourth one to be reported, Lash having reported a similar case in 1934 and finding only two before this in the literature.

The Present Status of Flexible Tube Gastroscopy—Borland, James L., Jacksonville, *Southern Medical Journal*, Vol. 30, No. 3, 310 (March) 1937.

"Flexible tube gastroscopy, having passed from a medical stunt to a safe, simple procedure," the author presents a summary of its status where it was used almost routinely in a clinic for fifteen months. The author believes that examination "should be offered every patient with a gastric complaint, without definite contraindications." The contraindications are severe general condition, lesions of the esophagus, and lesions outside of the esophagus which encroach upon it. Only five accidents occurred in thousands of examinations. These were perforations of the stomach. Three were sutured, two were left alone, and all recovered. The perforations occurred when a sponge tip was used. This tip has been abandoned and a rubber finger tip is now used. Most patients consider the procedure not harrowing and apparently have little discomfort.

Given a patient with a gastric complaint, it is possible to decide definitely whether a lesion is present. The extent and nature of the lesion can also be determined. It is possible in patients in the cancer age to determine whether or not cancer is present. The extent of the operation to be undertaken can be revealed to the surgeon. The course

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of the healing of an ulcer can be determined. A gastroenterostomy stoma for ulcer may be inspected. Dyspeptic cases may be divided into those with apparent organic mucosal changes and those without.

The Late Results of Radium Treatment for Uterine Hemorrhage of Benign Origin— HOLDEN, GERRY R., Jacksonville, Florida— *Southern Surgeon*, 4:98-103 (Apr.) 1937.

"This paper is based upon a study of 220 cases of uterine hemorrhage of benign origin, which, during a period of 13½ years, were given intrauterine treatment with radium," from 1920 to 1934. The average age of patients was 45½ years. Two hundred ten patients were married; ninety per cent of the married women had borne children. All but three patients were of the white race. Three types of uterine hemorrhage were considered. Group one consisted of nine young women with no gross abnormality in the pelvic organs. Light radiation to establish a temporary amenorrhea was given. In group two, there were 44 patients in whom hemorrhage was associated with myomatous uteri. "The remaining 167 patients had no gross lesions other than subinvolution and relaxation of the musculature of the fundus. . . . ." The predominating symptom in each case was uterine hemorrhage; either menorrhagia or metrorrhagia, or both. Diagnostic curetment was done in each case before treatment. Pelvic pain was present in the majority of cases. Pain was severe in only three cases, and the radium had to be removed before the appointed time. An anesthetic was used in the majority of cases. A preparation of radium sulphate, so screened as to cut out all but the gamma rays was introduced into the fundus of the uterus. The amount of radium varied from 25 mg. to 120 mg. The amount of radiation ran from 250 mg. hours to 5 Gm. hours. It was necessary to repeat the treatments from six months to a year in 9 cases. One hundred eighty-six cases of the 220 were traced.

No case is included in which the interval between treatment and report was less than two years. In the series there was no recurrence of hemorrhage due to the conditions present at the original treatment after two years of amenorrhea. Seventeen patients have died. Thirteen of these deaths were

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from medical conditions not connected with the pelvic organs; four died from various gynecologic conditions. One patient died of a carcinoma of the cervix seven years after treatment; one died of carcinoma of the ovary six years after treatment. The successful cases formed 92.9% of the series; the failures, 7.1%. Based on a study of the series presented, the type of case best adapted for treatment was the multipara about 40 years of age whose periods had become gradually more profuse for a number of years and who was tending towards metrorrhagia. In this type of case the general physical examination is negative. The fundus of the uterus is soft and somewhat large and the cervical canal dilated. There should be no evidence of malignant disease, trouble in the adnexa, or disturbances of pregnancy. In this type of case a high percentage of successful results may be expected.

Huge Bladder Calculus with Chewing Gum Core—McKenzie, Jack A., Miami, Florida—*J. of Urol.*, Vol. 37, No. 2, (Feb.) 1937.

A case is reported of a huge bladder calculus with a chewing gum core. The gum was rolled into the shape of a bougie and inserted into the urethra and used by the patient in masturbation to directly stimulate the verumontanum. The gum remained in the bladder for a period of three years, and the stone was larger than a goose egg. The author has been able to find only four cases in the recent literature in which chewing gum was used. In the cases reported, there was a total absence of symptoms for one year, and the patient kept the foreign body three years before consulting a physician. The stone was removed through a suprapubic incision and the patient left the hospital two weeks after the operation and within a month the incision had healed. The stone was 7 cm. in the longest diameter and 3.5 cm. in its shortest diameter. It weighed 75 Gms. In the center was an oval mass of chewing gum 2.5 cm. in its greatest diameter. The author comments that it is not apparent why a soft object extended through the urethra should be pulled up into the bladder instead of being washed out with the urinary stream. The possibility of traction being exerted on the object by the intermittent contractions of the muscles of the trigone, posterior urethra and sphincters is suggested.



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TO THE
FLORIDA MEDICAL ASSOCIATION, INC.

State Editor
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4437 Herschell St.,
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DUVAL COUNTY

The Annual June meeting of the Woman's Auxiliary to the Duval County Medical Society was held in the home of Mrs. E. W. Veal, with Mrs. D. E. Harrell as co-hostess. The reports of all officers and committee chairmen showed an increase in the activities of the Auxiliary during the year.

Outstanding accomplishments which were reviewed in the report of the president, Mrs. John Mitchell, were: the gift to the new Colored Tuberculosis Hospital of a suitable dish sterilizer; the sponsoring of the essay contest in Duval County High Schools on "The Problem of Ridding Florida of Tuberculosis;" the distribution of stickers to drug stores to be used on laxatives as warning against use in appendicitis attacks; cooperation in Christmas Seal sales and the President's Charity Ball ticket sales; the collection of physician's samples to be given to the colored hospital; the display of posters calling attention to the A. M. A. health broadcasts, and securing of time over Jacksonville stations for relaying these programs.

An enjoyable social hour followed the business meeting and delicious refreshments were served by the hostesses. Officers elected for the coming year are:

President, Mrs. J. H. Owens,
Vice-President, Mrs. F. W. Krueger,
Secretary, Mrs. D. E. Harrell,
Treasurer, Mrs. J. W Hayes

* * *

The Woman's Auxiliary to the Dade County Medical Society held its annual luncheon meeting June 14, at the Pancoast Hotel,

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Miami Beach. At the speaker's table were seated the past presidents of the Auxiliary and the officers of the year. After an interesting musical program and at the conclusion of the luncheon, the meeting was called to order by the president, Mrs. W. J. Barge. Noteworthy among the reports were: the Auxiliary's sponsorship of a talking motion picture on Tuberculosis, and a loan from the scholarship fund to a doctor's widow, enabling her to take a summer course at the University. Sixty members were present. The following officers were elected and will be installed November 8:

President, Mrs. R. O. Lyell,
First V.-Pres., Mrs. Edwin P. Preston,
2nd V.-Pres., Mrs. E. Norton McKenzie,
Recording Secretary, Mrs. S. P. Alderson,
Corresponding Sec., Mrs B. D. Carroll.

ADVERTISERS' NOTES

HOW "THE BIRTH OF A BABY" WILL BE SHOWN TO THE PUBLIC.

Forty-five hundred physicians and their wives attended the preview, at the Atlantic City Session of the American Medical Association, of the new talking picture film of The American Committee on Maternal Welfare.

The film was received with spontaneous enthusiasm and considerable praise of the acting, the photography, and of the great teaching work done by the Committee. Complete absence of advertising was noteworthy.

This is probably the finest medical film that has come from the motion picture studio and represents a new departure in that a lecture has been made so interesting, so dramatic that the audience lives with the actors on the screen and forgets that this is an educational picture!

The public exhibition of this film will be as ethical as was its production. It will first be shown to each state medical society, or, in the larger cities, to the city or county medical society. Upon its official approval, the film will be exhibited in every important community in that state or city. Local physicians and their families will be given a special free showing at one of the local movie houses, after which the film will be made available to the public, with whatever age restrictions, if any, may be recommended by the local medical society.

The film advertises no thing, person, or firm. It has only one objective: to educate the public to the need for maternal care and the value of the physician's services. Reaching millions of persons in the theatre, the film may well prove to be the most powerful single influence for effective public education that has yet been made available to the medical profession.

Every detail of the public exhibition of the film is carefully controlled: The exhibitor cannot add any sex or advertising picture in the same program with "The Birth of a Baby." Only approved lobby photographs, signs, newspaper stories, etc. may be used.

In other words, every precaution is being taken to the end that this extraordinary picture may remain dignified and forceful in its high purpose of educating mothers and prospective mothers on the importance of maternal care.

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The profession is indebted to the untiring efforts of the members of the Sub-Committee* of The American Committee on Maternal Welfare and also to Mead Johnson and Company whose generous financial aid and intelligent cooperation has made this important picture possible.

*Fred L. Adair, Prof. of Obst. & Gyn., U. of Chi. James R. McCord, Prof. of Obst. & Gyn., Emory U. Everett D. Plass, Prof. of Obst. & Gyn., U. of Iowa. Arthur J. Skeel, Specialist in Obst. & Gyn., Cleveland, Ohio. Philip F. Williams, Prof. of Obst., U. of Pa.

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BOOKS RECEIVED

Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.

TEN MILLION AMERICANS HAVE IT. By S. WILLIAM BECKER, M. D., Associate Professor of Dermatology and Syphilology, University of Chicago. A book on Syphilis for the general reader. Cloth. Price $1.35. Pp. 220. J. B. Lippincott Co.

NEW AND NONOFFICIAL REMEDIES, 1937. Containing descriptions of articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1937. Cloth. Price $1.50. Pp. 557, Chicago: American Medical Association, 1937.

SHADOW ON THE LAND. By THOMAS PARRAN, M. D., Surg. Genl., U. S. P. H. S. A simple, straight-forward story of syphilis and of its implications for the individual and the nation. Sets forth a program of ridding America of this plague. Cloth. Price $2.50. Pp. 309. Reynal & Hitchcock, New York.

THE CARDIAC GLYCOSIDES. By ARTHUR STOLL, D. Sc., M. D. Consists of three lectures delivered by the author in the College of The Pharmaceutical Society of Great Britain under the auspices of the University of London; embracing "The Importance of Sugars"; "The Squill Glycosides and the Structure of the Aglucones"; and "The Genuine Digitalis Glycosides". Cloth. Pp. 80. The Pharmaceutical Press, London, W. C. 1.

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COMPONENT SOCIETIES BY DISTRICTS—FLORIDA MEDICAL ASSOCIATION

Districts	County Society	President	Secretary	Meeting Date	Councilor and Counties Not Included in First Column	Members Total	Members Paid
N. W. District (A) Apalachicola, July 15, 1937	Bay	D. M. Adams, M. D., Panama City	Allen H. Miller, M. D., Millville		A-1-'38 John S. Turberville, M. D., Century	12	10
	Escambia	J. C. McSween, M. D., Pensacola	J. M. Hoffman, M. D., 1221 E. DeSoto St., Pensacola	2nd Tuesday 8:00 P. M.		39	34
	Walton-Okaloosa	A. G. Williams, M. D., Lakewood	R. B. Spires, M. D., DeFuniak Springs	3rd Thursday 8:00 P. M.		5	100%
	Washington-Holmes	G. W. Carter, M. D., Caryville	F. M. Watson, M. D., Chipley		*Santa Rosa*	7	6
	Jackson	C. H. Ryals, M. D., R.F.D. No. 1, Grand Ridge	Lewis Pierce, M. D., Marianna	2nd Tuesday 7:30 P. M.	A-2-'39 N. A. Baltzell, M. D., Marianna	15	12
	Leon-Gadsden-Liberty-Wakulla-Jefferson	L. L. Dozier, M. D., Tallahassee	B. A. Wilkinson,, M. D., Telephone Bldg., Tallahassee	Quarterly 3:00 P. M.	*Calhoun-Franklin-Gulf*	37	35
North Central District (B)	Columbia	T. H. Bates, M. D., Blanche Hotel Annex, Lake City	M. W. Spearman, M. D., Morrison Bldg., Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M. D., Lake City	13	100%
	Madison	E. Long, M. D., Madison	Geo. O. Davis, M. D., Madison			4	100%
	Taylor	G. H. Warren, M. D., Perry	J. C. Ellis, M. D., Perry	Last Friday 8:00 P. M.	*Baker-Dixie-Hamilton-Lafayette-Suwannee*	8	100%
	Alachua	T. A. Snow, M. D., 103 E. University Ave., Gainesville	H. M. Merchant, M. D., 124 E. University Ave., Gainesville	2nd Friday 7:30 P. M.	B-4-'38 A. B. Albritton, M. D., Wildwood	27	20
	Marion	Ralph E. Russell, M. D., Ocala	R. C. Cumming, M. D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P. M.		21	100%
	Pasco-Hernando-Citrus	W. Wardlaw Jones, M. D., Dade City	G. R. Creekmore, M. D., Brooksville	2nd Thursday 7:00 P. M.		13	100%
	Sumter	A. B. Albritton, M. D., Wildwood	W. E. Mitchell, M. D., Bushnell	2nd Tuesday	*Bradford-Gilchrist-Levy-Union*	4	100%
N. E. District (C) St. Augustine, Sept. 23, 1937	Duval	Kenneth A. Morris, M. D., 237 W. Duval St., Jacksonville	George W. Croft, M. D., 713 Greenleaf Bldg., Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M. D., Jacksonville	157	128
	St. Johns	Charles C. Grace, M. D., East Coast Hospital, St. Augustine	R. D. Harris, M. D., St. Augustine	3rd Tuesday 8:30 P. M.	*Clay-Nassau*	11	100%
	Putnam	H. A. Johnson, M. D., Palatka	F. Emory Bell, M. D., Palatka	2nd Thursday 7:00 P. M.	C-6-'38 Hugh West, M. D., DeLand	9	100%
	Volusia	J. Ralston Wells, M. D., Woolworth Bldg., Daytona Beach	R. L. Miller, M. D., 258½ S. Beach St., Daytona Beach	2nd Tuesday 7:30 P. M.	*Flagler*	40	35
S. W. District (D)	Hillsborough	George L. Cook, M. D., 442 W. Lafayette Tampa	James S. Grable, M. D., 811 Citizens Bank Bldg., Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M. D., Plant City	100	95
	Manatee	Lowrie W. Blake, M. D., Bradenton	M. M. Harrison, M. D., Bradenton	3rd Tuesday 7:00 P. M.		12	100%
	Pinellas	N. M. Marr, M. D., 812 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D., 1005 Equitable Bldg., St. Petersburg	1st and 3rd Fridays 6:30 P. M.		87	86
	Sarasota	O. H. Cribbins, M. D., 224 Commercial Court, Sarasota	J. E. Harris, M. D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P. M.		18	14
	DeSoto-Hardee-Highlands	Gordon H. McSwain, M. D., Arcadia	L. W. Martin, M. D., Sebring	2nd Tuesday 8:00 P. M.	D-8-'38 J. A. Simmons, M. D., Arcadia	19	100%
	Lee	H. Quillian Jones, M. D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M. D., 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P. M.		13	100%
	Polk	R. E. Gilbert, M. D., 19 Postal Arcade, Winter Haven	J. R. Boulware, Jr., M. D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	*Charlotte-Collier-Glades-Hendry*	60	55
South Central District (E) Melbourne, Oct. 21, 1937	Brevard	W. C. Page, M. D., Cocoa	Bob Schlernitzauer, M. D., Rockledge	3rd Tuesday	E-9-'38 W. C. Page, M. D., Cocoa	10	4
	Lake	LeRoy H. Oetjen, M. D., Leesburg	W. L. Ashton, M. D., Umatilla	1st Thursday 12:30 P. M.		17	16
	Orange	F. H. Harms, M. D. 64 No. Court St., Orlando	Hewitt Johnston, M. D., Box 2002 Orlando	3rd Wednesday 8:30 P. M.		58	56
	Seminole	H. D. Smith, M. D., Touchton Drug Bldg., Sanford	Douglas G. Scott, M. D., Box 489 Sanford	2nd Monday 7:00 P. M.	*Osceola*	13	100%
	St. Lucie-Okeechobee-Indian River-Martin	H. D. Clark, M. D., Ft. Pierce	Grover C. Hardie, M. D., Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M. D., Ft. Pierce	14	100%
S. E. District (F) Miami, Sept. 3, 1937	Broward	George S. McClellan, M. D., Pompano	Oliver C. Brown, M. D., 915 Sweet Bldg., Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'38 F. K. Herpel, M. D., West Palm Beach	29	100%
	Palm Beach	Bailey B. Sory, Jr., M. D., Brazilian Court Hotel, Palm Beach	Lloyd J. Netto, M. D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P. M.		55	51
	Dade	R. N. Burch, M. D., 1774 S. W. Eighth St., Miami	Walter C. Jones, Jr., M. D., 802 Huntington Bldg., Miami	1st Friday 8:30 P. M.	F-12-'39 H. A. Walker, M. D., Miami Beach	261	240
	Monroe	Harry C. Galey, M. D., 532 Fleming St., Key West	W. R. Warren, M. D., 511 Eaton St., Key West	1st Sunday 9:00 P. M.		8	100%



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American Medical Association San Francisco, June 13-17, 1938.
Southern Medical Association, New Orleans, November 30—December 3, 1937.

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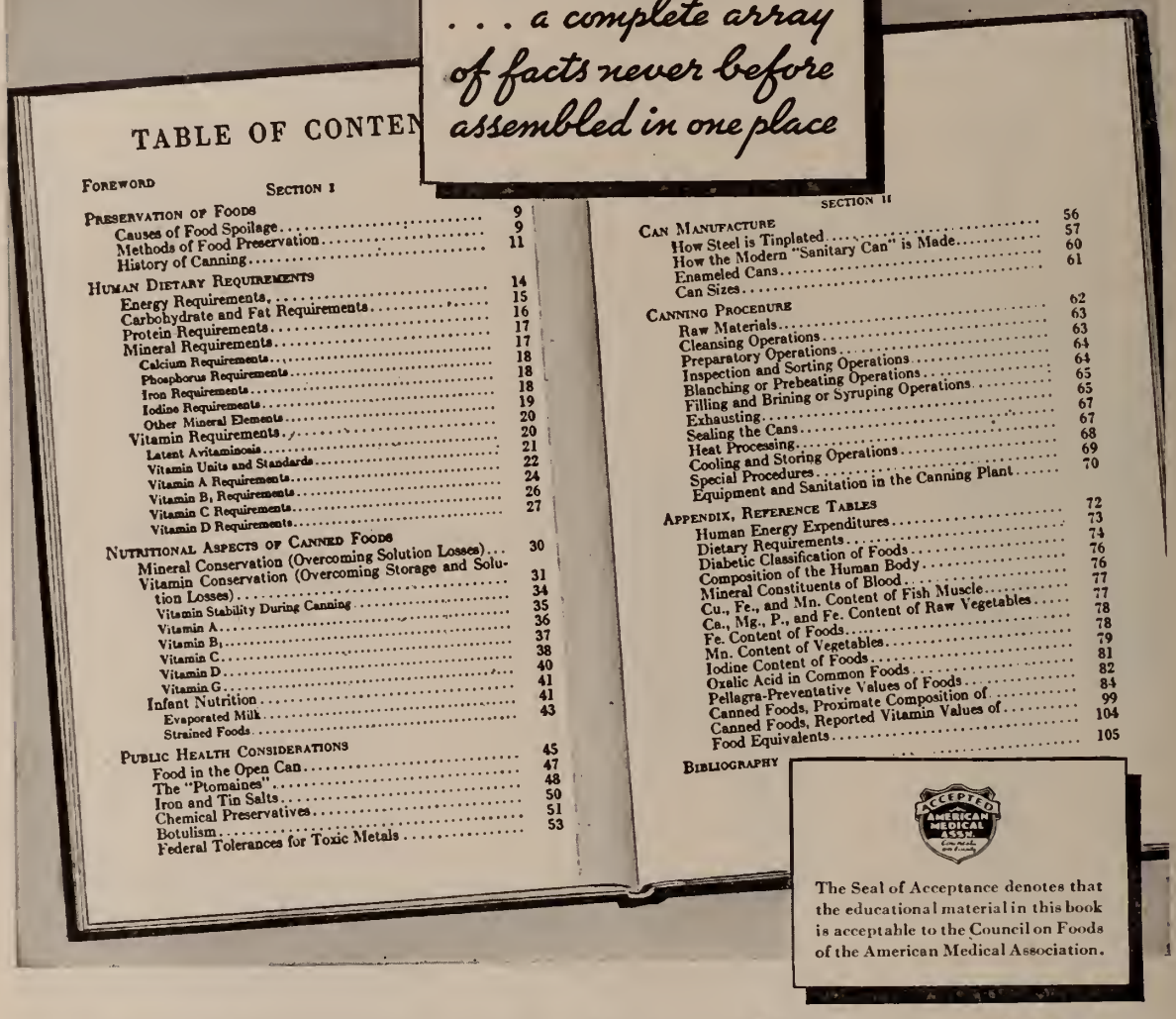
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[1] Cole, Harold N., *et al.; J. A. M. A.* 108:22, 1937.

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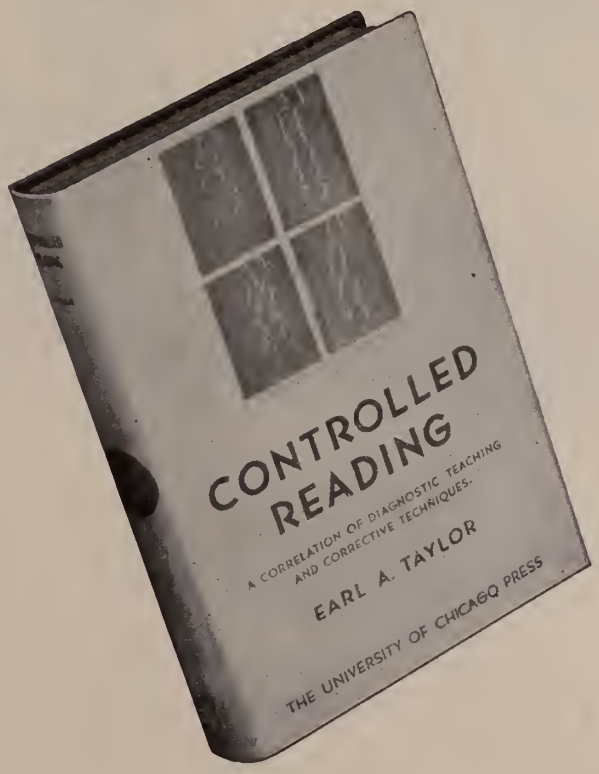
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HEART BLOCK*

T. Z. Cason, M.D.,
Jacksonville.

With the span of life being constantly extended, with cardiac diseases assuming increasing importance both as a handicapping factor and as a cause of death, heart block in its several aspects warrants relatively more consideration.

In reviewing some of the extensive literature on the subject of heart block, we are forced to realize that, while there are many established data on the histology and physiology, the etiology of the abnormal processes, and the pathology resulting from these disease processes, nevertheless much is yet to be determined. Undoubtedly, some of the generally accepted teachings must be materially altered as our knowledge of the mechanism of the heart action, both normal and abnormal, is better established.

Heart block may be properly considered under three separate headings: sino-auricular block, auriculoventricular block, and intraventricular block. Of similar pathological origin may be mentioned sudden cardiac standstill, resulting most often in sudden death, and auriculoventricular nodal rhythm.

The use, first of the polygraph of McKenzie and later of the electrocardiograph of Einhorn, has brought about rapid advances in our knowledge of the normal electrical conduction in the heart and the pathology resulting from disease of the heart.

SINO-AURICULAR BLOCK

This condition is rarely seen even in the large cardiac clinics. Sino-auricular bradycardia is not uncommon, is considered a normal condition, and is of no consequence, unless the whole heart rate drops below 40. When the rate is less than 40 we have a sino-auricular block. The sino-auricular block cannot be recognized in the electrocardiogram. Wenckebach[1] demonstrated two types of partial sino-auricular block which corresponded to the classification of Mobitz[2] of partial auriculoventricular block. These two types can be demonstrated electrocardiographically and a number of such cases, especially Type II, have been reported in the literature published in this country. deZarday[3] of Budapest reported quite recently a case of Type I, in which the auriculoventricular conduction impairment was also present. In Type I the P-P interval gradually increases until finally the PQRS complexes are dropped. In types II the P-P interval is uniform and after several normal PQRS complexes the auricular waves are dropped.

One of the most unusual cases of sino-auricular block reported was that by Strauss[4] in which there was not only sino-auricular block but also complete auriculoventricular dissociation without primary auriculoventricular block. Sino-auricular bradycardia can frequently be produced by vagal stimulation. Pressure over the right carotid will slow the heart by depressing the sino-auricular pacemaker due to vagal stimulation. This may also be produced to a lesser extent by pressure over the eyeballs and the left side of the neck. True sino-auricular block can be brought about by toxic doses of digitalis or quinidin sulphate. It is also due to tumors producing pressure on the neck and to infections of the neck. One of the cases recently reported by deZarday and already mentioned he attributed to an intracranial tumor.

Symptoms: Sino-auricular block is practically symptomless. Syncope from sino-auricular block is not distinguishable from Adams-Stokes' syndrome caused by auriculoventricular dissociation unless tracings are made. The one feature that stands out is the slow heart rate originating in the auricles. The roentgen examination is of little value. The electrocardiographic tracing is of great aid in making a differential diagnosis.

AURICULOVENTRICULAR BLOCK

Auriculoventricular block or dissociation is a condition in which, as the name implies, the normal relation in time in the contraction of

*Read before the Sixty-fourth Annual Meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, 1937.

the auricles and ventricles is broken. The specialized tissue known as the auriculoventricular bundle or the bundle of His connects the auricular and ventricular muscles. This bundle carries the excitation wave down from the auricles to the ventricles. Depression of the bundle of His produces a delay in conduction known as auriculoventricular block. Originally auriculoventricular block was known simply as heart block, being the first type of block to be recognized.

Auriculoventricular block is a normal condition in auricular fibrillation, auricular flutter, and auricular paroxysmal tachycardia, when the rate is very fast, 200 or over. Auriculoventricular block may be either partial or total, may be either temporary and functional or permanent and organic. Total auriculoventricular dissociation is where there is no relation in contraction time between the auricles and ventricles. There may be many grades of auriculoventricular block from slight delay in conduction to a 2-to-1, 3-to-1, or even 6-to-1 time. These lesser grades are known as partial heart block.

Though complete auriculoventricular block may be strongly suspected, the electrocardiograph is necessary for a positive diagnosis. The condition of complete auriculoventricular heart block is not common. Graybiel and White[5] recently reported 72 cases seen at Massachusetts General Hospital in 19 years among 14,000 electrocardiograms made. Ellis[6] reported 43 cases at Boston City Hospital between 1920 and 1931 taken from 7515 electrocardiograms. They make a careful analysis of their cases. Their findings and conclusions are very similar to those reported by other workers in large clinics where sufficient numbers of cases are seen to warrant drawing conclusions.

It should be noted, however, that almost certainly there occur many more cases of auriculoventricular block than carefully compiled statistics now indicate. This fact is due, of course, to their not being recognized and to electrocardiograms not being made, hence the importance of doing electrocardiograms on all cases of arrhythmias. No doubt with the much more frequent use of the electrocardiograph a higher percentage will be demonstrated in the future.

By far the largest percentage of all the cases reported are due to coronary heart disease. Among other etiological factors producing this condition are rheumatic, luetic, and congenital heart disease. Jones and White[7] in a study of 100 consecutive cases of diphtheria failed to find a single case in which there was evidence of heart disease. Graybiel and White[5] report four cases in their series occurring in individuals too young to be suspected of coronary disease, in which diphtheria was the only evident etiology. Ellis states that diphtheria was responsible for a small number of cases. Apparently the case against diphtheria is not conclusively proved. In view of our former timidity in treating cardiovascular syphilis energetically and adequately, it is interesting to note that those cases in which syphilis caused the heart block showed improvement when adequate treatment was given but failed to do so otherwise.

A few cases have been reported in which temporary auriculoventricular block followed coronary thrombosis. These are usually very serious cases. The relative occurrence of auriculoventricular block in men and women is about that in other heart disease where coronary sclerosis is the cause, namely, 2-to-1 or 3-to-1. Fibrosis of the bundle of His due to arteriosclerosis is the pathological lesion most frequently encountered. Other lesions due to etiological factors already mentioned are also found. In transient or functional auriculoventricular block, little or no pathology may be demonstrated; whereas, considerable pathology may be demonstrable with no block whatever evident.

Symptoms: Most authorities agree that auriculoventricular block produces practically no symptoms,—so few that the patient is not usually aware of this condition. While our own series of complete auriculoventricular dissociation is too small to warrant conclusions, none of the patients presented themselves with symptoms other than those found in and due to the etiological lesion. The block, *per se,* presented no symptoms. Adams-Stokes' syndrome, about which much has been written, is generally understood to be a syncope and epileptiform convulsion with an accompanying, marked slowing of the heart action. Complete standstill may last as long as 30 seconds. Adams-Stokes' syndrome is a serious symptom which does not frequently occur. Slight dizziness and faintness are not so uncommon. As already indicated in discussing sino-auricular

block, Adams-Stokes' syndrome is not to be confused with standstill produced by auricular depression. An electrocardiogram will differentiate. Auscultation may be of value in diagnosing auriculoventricular block. An extra sound occasionally may be heard when it is possible to differentiate the auricular contraction. This sound may be heard as a presystolic gallop rhythm. If it occurs in early diastole or in middle diastole or if the heart action is sufficiently fast, it will produce a middiastolic gallop rhythm. Actually, in high degree heart block the auricular sound may be heard at any phase of the ventricular contraction. The heart's response to exercise varies. Generally, there is an increase in rate, though not infrequently the reverse is true. The blood pressure is little affected unless the rate is low (30 or less), in which case there is a rise of the systolic blood pressure to 160 or more. It should be noted that roentgen study is of comparatively little value. The separate auricular and ventricular beats, however, can be detected frequently with the fluoroscope. Except in patients acutely ill of rheumatic heart disease (of which there are more in the Far South than previously supposed or recognized), auriculoventricular block is of no great significance in young people. In elderly people, however, all grades of auriculoventricular block are of serious consequence and should be so regarded.

When the excitation wave leaves the sinoauricular node, it passes down the right and left branches of the bundle of His to the subendocardial Purkinje network, thence to the ventricular muscle and outward to the pericardial surface.

BUNDLE BRANCH BLOCK OR INTRAVENTRICULAR BLOCK

This type of block is by far the most frequent, the most common cause being coronary sclerosis. Electrocardiographic tracing is necessary to make a diagnosis, though many cases can be detected from physical signs. King and MacEachern[8] give as the most constant physical sign "visible and palpable reduplication of the apex thrust."

Two general classifications are accepted, namely, left and right bundle branch block. The electrocardiogram in classical left bundle branch block has in Lead I the QRS complex upright, the T-wave inverted, while in Lead III the QRS complex is markedly inverted (a left axis deviation) and the T-wave is upright. On the other hand, in right bundle branch block, the electrocardiogram shows the QRS complex in Lead I inverted, the T-wave upright, and the QRS complex upright in Lead III with the T-wave inverted (a right axis deviation).

Graybiel and Sprague[9] after subdividing left bundle branch block into homophasic (when the T-wave and QRS complex take the same direction) and heterophasic, the classical left bundle branch block just described, make three other classifications, namely, right bundle branch block, heterophasic (already described), bundle branch block, intermediate type, and significant aberration of the ventricular complexes. Much has been written on the question of the exact origin of the depression producing the left or right bundle branch block. Much research was done before the present classification, which has been used only for the past few years, was accepted. Wilson and Herrmann[10] and later Barker, MacLeod, Alexander, and Wilson[11] should be given credit for this early work.

The etiology with accompanying pathology of bundle branch block is much the same as that of auriculoventricular block; coronary sclerosis predominates by far, syphilis and severe diphtheria being given.

Symptoms: There are no specific symptoms attributable to intraventricular block. The electrocardiograph differentiates bundle branch block from normal ventricular rhythm as well as distinguishes the various types of bundle branch block. Only by the electrocardiogram can this be positively done.

Sampson and Nagle[12] of the University of California Medical School recently reviewed with special reference to prognosis electrocardiographic records on 8000 patients, covering a period from 1913 to 1933. They call attention to the high mortality (20%) of bundle branch block the first year after the lesion is discovered, and the remarkable extension of life in the case of those who survive this one-year period. This condition occurs, as does auriculoventricular block, most frequently in the fifth and sixth decades of life. A finding of bundle branch block should be regarded most seriously and the patient carefully handled and closely watched for the first year.

Treatment: In every case the etiology of the lesion producing the block should be determined. When the cause is thus ascertained, treatment should be directed toward the etiological factor.

TREATMENT

Where toxemia from digitalis or quinidin produces heart block, the drug should be stopped at once.

In the case of rheumatic heart disease, long continued and energetic use of salicylates should be instituted.

Syphilis should be treated with all the armamentarium we possess. Following Moore and other authorities, I believe that the iodides should be given to the limit, followed by the heavy metals, and then the arsenical preparations, beginning with extremely small doses and working up.

Epinephrine hydrochloride should be given hypodermically or intravenously in sudden cardiac standstill, in syncope due to Adams-Stokes' syndrome, or in mild disorders of like nature.

Efforts have been made to break the block by the use of adrenalin and atropine. They are usually unsuccessful where the block is due to serious or well-established pathological lesions.

Either adrenalin or atropine may be of value in interrupting a temporary block, thus helping to make a differential diagnosis.

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DISCUSSION

Dr. Edwin C. Swift, Jacksonville:

I enjoyed Doctor Cason's paper very much. It brings out one salient fact, and that is, no heart study is complete without an electrocardiogram. Of course, it is true that many types of examinations are necessary but the diagnostic study should never be called complete until this examination has been made.

I want to discuss primarily the last phase of Doctor Cason's paper by bringing out two cases of heart block as illustrations. One man with failing myocardium was in bed. I saw him in convulsions for no apparent reason, until the pulse rate was found to be 30 then we saw what was happening: a typical picture of heart block with Adams-Stokes' syndrome. Large doses of atropine, intravenously, failed to stop convulsions. After a reasonable length of time a large dose of morphine was given and convulsions subsided in a few moments. The pulse rate remained unchanged and continued to remain in the neighborhood of 30 until his death. The electrocardiogram revealed complete heart block with an accompanying picture of the arteriosclerotic heart. General measures were taken and digitalis given in large doses over a period of two years. As long as we kept his myocardium functioning he did nicely; when that began to fail again, death intervened.

The second case was a man with hypertension who walked into the office complaining of myocardial pain. His blood pressure dropped from 240 systolic to 160 systolic, pulse rate was 30. Diagnosis: coronary occlusion with a heart block. Was immediately put to bed and given sedatives. Pain gradually decreased and blood pressure approached his normal. On the fifth day he had another attack of acute precordial pain and died. Up to the time of death the pulse rate remained around 30.

The point I want to emphasize is that heart block is primarily due to myocardial damage, and in treating the patient rest, sedatives and specific therapy should be directed toward improving the condition of the myocardium. As for specific therapy, quinidin may be of value

in some cases but digitalis is our drug of choice. Heart blocks which are found in the aged may continue for two or three or four years. General physical conditions, blood pressure, etc., may apparently return to normal and then the patient usually eventually dies of the myocardial disease which originally caused the heart block.

Dr. William C. Blake, Tampa:

I enjoyed Dr. Cason's paper very much. Heart block is one of the frequent manifestations of coronary disease. Auriculoventricular block may be temporary and functional due to toxic states or due to large doses of such drugs as digitalis or quinidin. On the other hand, it may be permanent and due to structural change. The common underlying pathology is sclerosis of the small arteries supplying the junctional tissue and the A-V node. At first the block may be temporary but finally as the circulation becomes more interfered with the block becomes permanent.

In a series of intraventricular block, Jones and White considered that 84.6% were due to coronary disease.

TETANUS*

Jos. S. Stewart, M. D.
Miami

Any discussion of tetanus must necessarily be separated into two distinct divisions, prophylaxis and treatment; the one dealing with the germ, the other with the toxin elaborated by the germ.

Prophylaxis

The Bacillus tetani (*Clostridium tetani*) grows in the absence of oxygen and thrives only in the presence of contused tissue and infection by other organisms. The laboratory[1] informs us that washed spores when injected into healthy tissue will not grow but that these same spores injected into contused or contaminated tissue will grow luxuriantly. Clinical experience bears out these experimental results.

What then is proper prophylaxis? No words need be wasted on the universally recognized value of tetanus antitoxin. I take it for granted that every man uses it routinely. But, should prophylaxis stop here?

The bacillus flourishes in a favorable site but there it remains. There is no spreading infection, no septicemia. By its spore-forming ability it may lie dormant for weeks or months until favorable surroundings spur it on to growth.

Prophylaxis must not stop with tetanus antitoxin. The wound must be made unfavorable for the germ. Closed wounds must be eliminated and foreign bodies removed. Secondary infection, so necessary for its growth, must be controlled. It is only by debridement that foreign material and contused tissues can be seen and removed, and punctured wounds made into open wounds. Debridement makes the site unfavorable. My patient W. P., age six, stuck a clean nail in his foot. Tetanus antitoxin, 1500 units, was given. Three months later he developed tetanus. Small wonder I favor debridement. Two patients in our Jackson Memorial Hospital series received prophylactic serum but developed tetanus and died. In a series of one hundred and eighty-five cases reported by Boyce,[2] seven patients received the serum but developed tetanus, and five died. My patient W. P. would not have developed tetanus had I followed the procedure that is now routine—debridement. Dumitresco[3] reports a case with relapse six months after the initial tetanus. The mere injection of 1500 units of tetanus antitoxin is no longer considered adequate treatment of contused or punctured wounds. My plea is that punctured wounds, such as nail wounds to the sole of the foot, be excised and that splinter wounds be opened to their depth.

I thoroughly agree with the many who condemn the use of phenol[9] or other cauterants for surely their very use, theoretically at least, prepares an ideal soil for the growth of the very organism they are used to destroy. Does not the cauterant devitalize the tissue and does not the coagulum form, not only a foreign body, but one that excludes oxygen?

The importance of readministration of prophylactic serum in deep and severely lacerated wounds and compound fractures is often overlooked. It is well to remember the ability of the spores to lie dormant and, since the serum remains in the body for only fourteen days, a second or even a third injection is frequently indicated.

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*Read before the Sixty-Fourth Annual Meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, 1937.

SUMMARY OF PROPHYLAXIS

1. Give prophylactic tetanus antitoxin.
2. Make the wound unfavorable to the growth of the bacillus by
   a. Debridement.
   b. Excision of punctured wounds.
   c. Incision of splinter wounds.
3. In deep and severely lacerated wounds and compound fractures give additional doses of tetanus antitoxin.

THE DISEASE

The modern conception of tetanus may be stated thus: a disease of the central nervous system purely and solely; caused by a toxin elaborated by the *Clostridium tetani* which is carried to the spinal cord, medulla, and pons, by the peripheral motor nerves of the host. The scope of this paper does not allow a discussion of this theory nor of the theory advanced by Abel[1] and his associates at Johns Hopkins University. But, since to my mind, no paper on tetanus today can be complete without full recognition of the value of Abel's work a few of his conclusions will be stated and the reader is referred to his remarkable papers for interesting details.

The conclusions of Abel completely upset the modern conception of the disease. First he believes the disease not one "purely and solely of the central nervous system" but primarily one of the susceptible voluntary muscles and secondarily of the cord; the first resulting in the muscular spasm that causes death, the second in the intermittent and reflex convulsive seizures. Second, he believes the toxin is carried to all organs and tissues by the blood and lymph and that the peripheral motor nerves have nothing to do with it. Third, he believes that the incubation period varies in relation to the amount and virulency of toxin formed and has no relation to the distance from the cord of the primary wound. Fourth, he believes with many others that once the toxin has been fixed by the susceptible tissues no amount of antitoxin will neutralize it.

Since Wainwright's[7] report in 1926 there has been an ever increasing number of reports in the literature doubting the efficacy of intraspinal serum.[5, 2, 8, 9, 10, 11, 16] I feel that Abel has now placed such administration definitely in the realm of the past.

The conception of the treatment of tetanus which I wish to bring before you is one that has arisen from the experience of clinicians throughout the world during the past several years. No one man is responsible and certainly no originality is claimed.

The principles may be stated as follows:—

1. Neutralize circulating toxin by intravenous tetanus antitoxin and prevent further absorption by excision or debridement of the offending wound.
2. Control as well as possible muscular spasm and reflex convulsions by sedation.
3. Given adequate fluid and nourishment by nasal catheter.
4. Give specialized nursing care in quiet isolation.

Clinical and experimental experience have so positively proved that antitoxin has no effect on toxin already fixed and causing symptoms that we no longer attempt to treat the disease by serum. Serum given is for the purpose of preventing any additional absorption. We therefore advise the intravenous administration of serum at the first suspicious symptom and we deplore the usual waiting around for additional signs. Every hour of waiting means that more toxin is fixed and thus the danger of spasm of the muscles of respiration is increased. We subscribe to the principle of a general anesthetic with excision of the wound of entrance and the intravenous administration of tetanus antitoxin diluted in saline.[12, 16] Skin tests are always given even after negative answers to the usual questions in regard to previous serum, asthma, etc.

When this first injection has been given and the focus of infection removed we feel that antitoxin is thereafter not only useless but conducive of harm especially if given seven or more days following the initial dose.[5, 6]

The real difficulty in treatment now begins. The ideal drug is yet unknown. With chloral, the barbiturates, and avertin, we can do wonders, but the difficulty is great. A special nurse is necessary and observation by a doctor every few hours essential. The work of Cole,[12] Läwen,[13] Momburg,[14] Boyce,[2] and others on continuous avertin anesthesia makes this method appear to be the most promising. Cole[12] used it in one case for twenty-five days, varying the daily dosage to suit indications. He found that oxygen had to be administered

constantly or occasionally, depending upon the amount of avertin found necessary to obtain relaxation. In a recent case, P. P., age seven, I found sodium amytal and luminal satisfactory in preventing convulsions and in partially relieving muscular spasm. Until more information is obtainable on the pulmonary complications of continuous avertin anesthesia it might be wise to suggest the use of the barbiturate most familiar to the physician in charge. The dosage must not be routine but changed from hour to hour as the presenting symptoms indicate. In a later report I expect to discuss my experiences with continuous avertin anesthesia.

Curarine as used at present is dangerous and of questionable value. West[15] treated ten cases with nine deaths and advised against its use except in extreme cases. Florey[16] considers its use advisable only in specially equipped hospitals with Drinker respirators available.

My experience has led me to look with fear on the intraspinal and intramuscular use of magnesium sulphate, and I have abandoned it. Fantus[9] uses it routinely in severe cases.

It would seem unnecessary to suggest that great pains be taken to see that a sufficient volume of fluid be given. My experience has taught me that without personal daily directions, with detailed records of intake and output, sufficient fluid and nourishment will not be given. The nasal catheter is my standby With proper sedation its use is well tolerated. By no other method is the required amount of nourishment and fluid so efficiently and easily administered.

SUMMARY

I believe that tetanus antitoxin is valueless in the treatment of established tetanus. Its use is recommended at the first suspicious symptom to neutralize circulating toxin thereby preventing further fixation. It is recommended that from twenty to sixty thousand units be diluted in 300 cc. of normal saline solution and given intravenously while the patient is under a general or avertin anesthesia. No need is seen for additional doses. Intraspinal serum is especially condemned. Complete debridement or excision of the offending wound is recommended to prevent further formation of toxin. All hope of curing the patient is placed on expert nursing care, sufficient sedation carefully controlled, and the administration of adequate nourishment and fluid. Until a drug is found that will either neutralize fixed toxin or counteract its effect the mortality from the disease will be high.

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DISCUSSION

Dr. W. Duncan Owens, Miami Beach:

Dr. Stewart has covered his subject so thoroughly and he has had such a wide experience with tetanus down in Miami that he has left little to be said.

In order to treat tetanus either actively or prophylactically with any real degree of success one must admit and subscribe to Dr. Abel's conclusions: that the toxin of tetanus is (1) produced only at the site of the lesion, (2) absorbed there by the capillaries of the blood and especially of the lymphatics, (3) carried only by the blood stream to other tissues, including the central nervous system where (4) fixation immediately begins in those tissues that have an affinity for the toxin.

It has been pointed out that tetanus bacilli thrive only in contused or infected wounds. It therefore seems well to stress again two points indicated: debridement or excision of the lesion both as a prophylactic measure and especially to remove the focus of growth in the full-blown case and to decry against the use of any cauterants. Such agents not only so injure the tissues as to furnish the most favorable medium for the reception and growth of the bacilli but also, by forming a coagulum, so seal the wound that all possible contact of oxygen is prevented; this coagulum also acts as a foreign body.

After debridement or excision the ideal dressing is one that will supply oxygen directly to the focus; hydrogen or zinc peroxide or perborate solution as wet dressings have given excellent results.

In conclusion I wish to agree most heartily with Dr. Stewart that fluid balance must at all times be maintained during the course of active treatment.

Dr. T. H. Bates, Lake City:

Something that Dr. Stewart said brings to mind the fact that the prevention of tetanus is a grave responsibility and certainly the outlook now is not as dark as it was when we had to depend on the 1500 units prophylactic antitoxin.

Alum precipitated toxoid today is working satisfactorily in the prevention of tetanus. Unfortunately, it cannot be given in just a single dose and must be stretched over a period of two months. However, two inoculations 60 days apart will do it.

Dr. George L. Cook, Tampa:

I want to add a word of praise for this very excellent paper and to mention, as has the last speaker, the importance of prevention of tetanus by the administering of tetanus toxoid.

During the past several years, I have been giving to my allergic children, a dose of tetanus toxoid which I repeat in one month and thereafter when there is an occasion for administering the tetanus antitoxin, give them another dose of toxoid and care for the wound as has been outlined. This seems to be a safe and sound procedure. When you are dealing with allergic children and it becomes necessary to give them tetanus antitoxin, you are assuming a grave responsibility. Serum reactions in this type of individual are oftentimes very difficult to control.

I urge the administration of tetanus toxoid, as it has been more or less perfected and which we believe to be safe as a protective agent against tetanus.

Dr. Joseph S. Stewart, Miami (concluding):

I am delighted that it came out in the discussion about the alum precipitated toxoid. It does not change our conception of the prophylaxis at all, however. If you are fortunate enough to have a patient who has had the toxoid, please go ahead and do the debridement. We do not know just how valuable the alum precipitated toxoid will be but it will not change at all the idea of removing the source of infection by debridement and removing infection by the proper treatment of the wound.

MEDICAL ASPECT OF POSTOPERATIVE CRISES*

M. Jay Flipse, M.D.,
Miami.

In this review of the medical aspect of postoperative crises, we will consider essentially the complications arising in the cardiovascular and pulmonary systems with a few remarks on surgical diabetes if time permits.

A—Cardiac Abnormalities:—

1—Cardiac arrhythmias.
- a—Sinus arrhythmia.
- b—Sino-auricular standstill.
- c—Premature systole.
- d—Paroxysmal tachycardia.
- e—Auriculoventricular block.
- f—Auricular flutter.
- g—Auricular fibrillation.

2—Coronary occlusion.

*Read before The Dade County Medical Society, Miami, Jan. 5, 1937.

B—Vascular Abnormalities:—
1—Thrombosis and embolism.
2—Thrombophlebitis.
C—Postoperative Shock.
D—Postoperative Hemorrhage.
E—Pulmonary Complications:—
1—Postoperative pneumonia.
2—Postoperative massive collapse.
3—Pulmonary abscess.
F—Diabetes.

Cardiac arrhythmias may be of minor or major importance. If a careful heart examination precedes the surgical procedure, many postoperative cardiac conditions can be avoided by proper choice of anesthetic and limitation of the extent of the surgery.

Among the minor cardiac irregularities may be mentioned sinus arrhythmia, premature systole and sino-auricular standstill. These conditions are important only for differential diagnosis and require no treatment. The more serious irregularities — auriculoventricular block, paroxysmal tachycardia, auricular flutter and auricular fibrillation may result disastrously unless recognized and given appropriate treatment.

Auriculoventricular block is most frequently due to rheumatic heart disease or coronary sclerosis. Both of these factors may be suspected from history or physical examination before operation. The diagnosis is readily established by electrocardiography. In partial block, the heart action is normal but the electrocardiogram shows a prolonged conduction interval. In complete block or auriculoventricular dissociation, the auricles and ventricles beat independently with a pulse rate of 20 to 50 a minute. Either partial or complete block may be compatible with successful surgery under well controlled conditions. The crisis develops from a shifting of a partial to a complete block after anesthesia, especially if digitalis has been given. This shift is often accompanied by syncope or convulsions and constitutes the Adams - Stokes' syndrome, which is very disconcerting but ordinarily not fatal. Treatment with ephedrine, adrenalin and barium chloride or sometimes thyroid usually controls the symptoms. Digitalis is contraindicated and may produce a fatal attack of total block in cases of partial block.

Paroxysmal tachycardia is a condition of tachycardia with cardiac rate of 150 to 250 a minute. The attack is of sudden onset, is usually associated with heart consciousness and sometimes with symptoms of circulatory or cardiac failure. It may occur in hearts without organic disease but is possibly more frequent in cases showing damage from rheumatic or sclerotic heart disease. The onset of the attack is sudden, heart action is rapid but regular. The attack terminates suddenly after a few minutes or few hours or, occasionally, may last several days. I have seen but one case terminate fatally from congestive failure after three days of continuous tachycardia. Treatment with vagus stimulation, quinidine and morphine is usually successful.

Auricular flutter and fibrillation are irregularities usually due to organic heart disease. In flutter, the heart action is regular and usually rapid; in fibrillation the heart action is totally irregular. Both conditions are usually amenable to quinidine but digitalis is also indicated where quinidine is not successful. The development of congestive failure may be expected in uncontrolled paroxysms.

Discussion of cardiac crises would not be complete without mention of coronary occlusion or embolus. I have seen a number of patients in whom coronary occlusion occurred during the course of a surgical procedure. In one man of forty the occlusion developed during a sinus operation; in another of the same age, cholecystectomy induced the attack; and in a third case, a young woman in her early twenties, pelvic operation was the causative factor. In all these cases, the diagnosis was overlooked for several weeks until medical consultation was obtained and the suspicion corroborated by electrocardiography. The symptoms of angina were typical but were interpreted by the surgeon as manifestations of gas pains. The diagnosis and treatment are no different in postoperative coronary occlusion than in non-surgical cases of similar type but the possibility of this condition must be remembered.

Vascular accidents of thrombosis and embolism are unfortunately on the increase because of the extension of surgical benefits to those in the more elderly age brackets. The dramatic suddenness of a pulmonary embolism

and the high mortality resulting from this complication mark it as a risk which should always be considered in any surgical procedure. The clinical picture is typical and undoubtedly familiar to all. If death does not result immediately, supportive measures with adrenalin and oxygen tent may pull through a few cases.

Thrombosis may occur in cerebral or coronary vessels — or more frequently in the lower extremities. Acute arterial occlusion in the lower extremities may now be treated with Pavaex and, in my experience, has given nearly 100 per cent cure in cases where the remedy was immediately applied. An interesting theory has been proposed by Paschoud and Havlicek to explain the mechanism of thrombosis. These observers postulate a reflux of portal blood into the systemic venous circulation through the iliac and femoral veins and show the tendency for such mixed blood to coagulate easily. While this theory may be a possibility, the more probable cause of arterial occlusion is the slowing of the circulation in the lower extremities and the tendency for the blood to clot in arteriosclerotic vessels.

Thrombophlebitis is a relatively common complication which while painful and annoying is usually not fatal. It should be differentiated from arterial occlusion by the edema and local evidence of inflammation with which it is associated. Pavaex is absolutely contraindicated in thrombophlebitis because of the danger of separating emboli from the clot.

Postoperative shock, collapse, and hemmorrhage are too common to require description. Their prevention through good choice of anesthetic and minimal surgical procedures is better than their treatment with adrenalin, caffeine and intravenous fluids, blood or colloidal solutions.

Pulmonary Complications:

Postoperative pneumonia is a not uncommon complication especially in upper abdominal surgery. It is not avoided by non-inhalent anesthetics such as avertin. The best preventive would seem to be a careful anesthetic with avoidance of aspiration of gastric and salivary secretions into the lung and hyperventilation of the lung in postoperative cases by means of carbon dioxide inhalations. Early and frequent change of posture especially in elderly patients is good practice.

Postoperative massive collapse of the lung is oftentimes overlooked. When urgent, the symptoms may be completely alleviated by a small artificial pneumothorax on the affected side. However, before this heroic procedure is instituted, attempts at hyperventilation with CO_2, oxygen and possibly aspiration of the affected bronchus through a bronchoscope should be considered. Pneumothorax is, however, not a dangerous procedure and if properly given will result in complete cure of massive atelectasis.

Pulmonary abscess is a common postoperative complication especially following tonsillectomy. It probably is due to aspiration of infected material from the throat. In one series of lung abscess cases, 52 per cent had a history of the development of symptoms after tonsil operations. Care in aspiration of the blood from the throat during tonsillectomy and a bloodless field before the patient leaves the operating table will do much to reduce the incidence of lung abscess.

SURGICAL DIABETES

Thanks to insulin and a better knowledge of diabetes, operative procedures are now perfectly safe on diabetics—*provided* the diabetes is recognized before operation and that a combined medical and surgical supervision is afforded during the illness. The chief danger in surgery on diabetics is in that group in whom an unrecognized potential diabetes exists prior to operation. In such cases it is not infrequent that severe acidosis develops postoperatively. A good rule to follow is routine urine examination both before and after operation, with blood sugar studies in all cases of glycosuria. Since the incidence of diabetic coma and other complications has not been reduced in the last ten years, it is obvious that the general practitioner is not adequate in his knowledge and control of his diabetic patients. Therefore, when diabetic patients require surgery, the medical supervision should be under the direction of some one who is thoroughly familiar with this phase of diabetic treatment. Time does not permit a detailed description of the method of procedure. Those who are interested are referred to such texts as Joslin's monograph and the numerous excellent articles in the literature.

Permit a final word in the conclusion of this subject; the essence of correct surgery not

only in diabetics but in all patients is the co-operative supervision of the patient by a group of physicians, each competent in his own field. The family doctor is especially valuable because of his knowledge of the patient and the confidence of the patient in his personal interest. However, the skill of the surgical consultant and possibly the specialist in other branches of medicine may be of inestimable value in certain cases. Where the finances of the patient are such that he is unable to afford a paid consultant, nominal or no consultation charges should be the rule as a courtesy to the attending physician. Only through such co-operative supervision can the best results be obtained.

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DISCUSSION

Dr. Bascom Palmer, Miami:

I wish to take exception to the word "frequent" used in connection with lung abscesses following tonsillectomies. I think this word can hardly be applied to the existing conditions in Miami,—most likely due to the climate. During my fifteen years of practice here in Miami I know of only one case of my own of postoperative lung abscess, and this was referred to Dr. Flipse, who confirmed my diagnosis. A bronchoscopy was done and the patient made a complete recovery. I know of no other case of my own or my confreres. I am still inclined to believe the climate has a lot to do with the lack of postoperative lung abscesses here.

Dr. M. Jay Flipse (concluding):

It is quite possible that the climate plays some part in the elimination of lung abscesses following tonsillectomies, but I still believe that the technique and type of anesthesia play a greater part. I recall the case which Dr. Palmer mentioned. This was caught in the early stages of a potential abscess and treated with success. Dr. Palmer does his tonsillectomies under general anesthesia with the head lower than the chest, with continuous suction so that the possibility of aspiration is lessened, and this accounts for the lack of complications.

I want to state now that I do not think that a general practitioner should remove tonsils, as it is much more difficult than we are inclined to believe. I suppose that we have all done this,—especially during our internship.

I recall another case of postoperative lung abscess following tonsillectomy. This was Dr. Mentzer's case, and he was called in so late that by the time the case was diagnosed it was too late for successful treatment.

WORSHIP OF THE SUN*

L. S. Oppenheimer, M.D.,
Tampa.

It is not necessary to turn back the pages of history to be convinced that today we, self-styled civilized people, are still faithful worshippers of the sun, though not in the same spirit or manner as were the ancients.

About 4000 years B. C., or about 6000 years ago, the Chinese paid homage to an immense idol representing their sun-god of gods. About 3000 years B. C. the Assyrians (Abraham's nation) and the Babylonians worshipped Shamash, their sun-god; Japan had her sun-goddess, Tiayo, a feminine deity from whom they claim their Mikados are descended. They call their Isle of Nippon the "Empire of the Sun," and emblazon that orb on their banners. The Persians worshipped their sun-god, Baal, the Philistines their sun-god, Mithras, the Druids and the Brahmins their sun-gods, idols; the Greeks their Helios, the Egyptians their Ra, from whom they claim all their Pharoahs are descended. Mexico, Peru and other South American countries still contain the ruins of many temples erected to the sun. The sun-dance of many North American Indian tribes is still an annual celebration to the sun. It occurs in the early weeks of July, and lasts from five to ten days, and consists of incantations, dances, prayers, sacrifices, and an orgy of savage customs and acts.

They recognized one great truth, as we do, that all life on earth proceeds directly from the sun. In fact, if the rays of the sun were completely blotted from the earth man could live but 36 hours.

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*Read before Hillsborough County Medical Society, Tampa, March 2, 1937.

The sun is 93 million miles distant; its light traveling at the rate of 186,376 miles per second takes 8 minutes 20 seconds to reach us; it revolves on its axis once in 25 days; the temperature on the outside is between 6000 and 7000 degrees Celsius, and on the inside, estimated over a million. On the sun's surface are well known spots which are slowly changing from time to time, exerting a powerful influence on terrestrial weather, and are therefore exceedingly important phenomena. During the present and past year these spots have been unusually numerous, active, rapidly changing; and coincidentally storms, tornadoes, hurricanes, floods, earthquakes, etc., have been more violent and destructive than at any time in history. They are said to be more numerous and active about every eleven years. The next peak will be in 1939.

As further corroborative evidence of the influence of sun-spots on terrestrial physics, Harry Lawton, a free-lance astronomer at New Orleans, claimed last month that he had found a sun-spot 125,000 miles long, nearly double the size of the average spots. About the same time Astronomer Lucien d'Azambuja of the Paris Observatory found, with his powerful spectrohelioscope, flaring "prominences" shooting out 90,000 to 180,000 miles from the sun's surface, the most intense solar activity in 20 years. During the same week the report came from Pasadena, California, astronomers that a sun spot had appeared into which 40 planets the size of the earth could have been tossed. Before the present 11 year sun-spot cycle began in 1933, astronomers were unwilling to recognize any effect on this planet except a disturbance in the earth's magnetic field, possibly a slight influence on the weather, and evidence that violent radiation increases with the spots.

Within the past 18 months, however, more than 40 short wave radio fade-outs have been observed to coincide with "chromospheric eruptions in the neighborhood of sun-spots and magnetic disturbances," on earth.

Sun-spots appear to be the whirling mouths or funnels of gas originating in the interior of the sun, and are due to the shifting combination of gravitational pulls by the planets.

The sun's rays to reach us must traverse several hundred miles of atmosphere surrounding the earth, consisting of three merging layers. The lower, about ten miles deep, is called the troposphere; the middle, the stratosphere, about 60 or 70 miles deep; the upper, the ionosphere, the electrified layer, which has been estimated at 300 to 400 miles deep, stops radio waves and reflects them back to earth. This electrification is said to be produced by the sun's ultraviolet rays. Sunlight passing through these, loses nearly 25 per cent of its energy.

At sunset the sun is visible for several minutes after it has sunk below the horizon, due, as you all know, to the refraction of its rays through the convex layer of the atmosphere. Clouds, mist, fog, smoke, dust, etc. are potent factors in filtering out much of the rays.

The rays are more direct, least refracted, most effective at meridian. Ultraviolet rays are reflected from clouds, water, sand, snow, etc. This explains why people while bathing, fishing, swimming in cloudy weather get sunburned, or tanned, although apparently protected from the sun's direct rays. Clothing, certain colors, most kinds of glass and many other things interfere with the penetration of ultraviolet rays, quartz glass being the only glass that offers no obstruction. Clear celluloid obstructs only part of the rays.

The properties of solar radiation differ vastly in different sections of the earth. Florida sunshine is universally conceded to possess peculiar properties, more vital actinic rays all the year round than any other state or country. The state has therefore been named "The Empire of the Sun," and has become the mecca of health seekers. In only two other states does the sun shine more days than in Florida, but the actinic, chemical rays fall short of the latter. In the New York district it is said that direct sunshine at noon on a clear day produces sunburn forty times quicker in summer than in winter.

The Smithsonian Institute has selected Mount St. Catherine, supposed to be the Mount Sinai of the Bible, rising 8,540 feet above the Sinai Desert, as one of the ideal locations for a solar observatory.

The National Geographic Society has appropriated $65,000 to enable the Smithsonian staff to maintain a solar observatory for six years on Mount Boukharos in southeast Africa, to study solar phenomena, especially in relation to forecasting long range weather conditions.

A light year, meaning the distance light travels in one year, is 5,880,000,000,000 miles, and requires thirteen figures to express. Our entire galaxy, the Milky Way, rotates about a center in the constellation Sagittarius which lies at a distance of 32,500 light years from our sun. The sun with its planetary system rotates about this center at the rate of 175 miles per second, and requires 224 millions of years for one rotation.

Richie, the famous astronomer of Mount Wilson Observatory, with its 108-inch lens, says that it is not improbable that among the smallest nebulae seen in the vicinity of H II 240 Pagasi are some as distant as one thousand million light years. Among those measured thus far is one in Bootes at a distance from the earth of 240 million light years, which moves with a velocity of 24,400 miles per second.

We talk lightly nowadays of billions. Do you realize just how big a billion is? If a man will count one every second, day and night, it will take him over 31 years to count one billion. Count it yourself. Then if you wish, write to the Secretary of the U. S. Treasury to inform you how the billions of gold and currency in the Treasury are counted.

There are many suns thousands of times larger than ours, millions of light years away, some surrounded by a million stars. The new 200-inch telescope of the California Institute of Technology now in their laboratory, will require three more years to finish. It will be installed in an enormous observatory on top of Mt. Palomar, near Los Angeles. The astronomers say it will enable us to see 100 times farther than is possible at present.

Much progress has been made in the last decades in the practical use of the sun's rays. Prominent in this field is the conversion of light impulses into electrical impulses. The photo-electric cell has made possible the talking picture, television, dynamic radio energy and other products by the transformation of light waves into electric energy, and this into dynamic energy and sound waves.

This is accomplished by light waves caught by the photo-electric vacuum cell, striking the lining of helium or potassium hydride in the cell, knocking loose electrons which are caught and carried as electricity on wires, to be amplified through a succession of vacuum tubes, similar to those on the radio, and thus transformed and magnified at will. Dr. Petit of Mount Wilson Observatory says that it is entirely within the range of possibility that at some future time we will be able to get our major supply of power from the sun.

Nothing presents a more colossal evidence of the conservation of solar energy than the strata of coal in which vegetable and animal life has been buried for millions of years, miles beneath the present earth's surface, crushed by overlying mountains. These, brought again to the earth's surface in the shape of crude elements, coal, tar, oil, gas, etc., have yielded products through the ingenuity of science which have given us a monumental variety of most useful synthetic objects, too vast for detailed discussion here: hundreds of perfumes from Attar-of-roses, Jockey Club, Musk, Christmas Night, etc., to the most delicate of odors, thousands of dyes, analines, etc., outvieing in variety and brilliancy all other hues to be found in the world, in art or nature; thousands of chemicals, drugs, fertilizers, explosives, war gases, etc., and many other objects of human value; and these in one field of nature alone.

Thus has the scientist released millions of fertile acres for food crops formerly devoted to raising materials for dyes and drugs. The key to the whole mystery of color has been gained, so that we can now produce dyes of any given qualification as to color, stability, resistance to soap, water, light, etc., even to making combined or iridescent colors.

More vitally important to us, however, than the aforementioned knowledge revealed by the astronomers and the physicists, is the influence of sunlight on our own health, and its practical value in our daily lives.

The sun shines upon our food products, plant and animal, and thus secondarily shines within us in the body's protoplasm. There-

fore, what we eat is the product of the sun's radiation. And this radiant energy is converted within us to dynamic energy. This life-sustaining radiation is said by Dr. Crile of Cleveland to release electrical currents within the body to perform its manifold functions.

Heliotherapy, the treatment of disease by means of light, has become a specialty in itself. To appreciate its importance one should have some knowledge of the fundamental laws of solar energy.

The long waves of the spectrum (sunlight broken up into its component parts) are the heat rays, i. e., yellow, red, infra-red, (invisible) and Hertzian waves of the radio. At the other end of the spectrum are the short or chemical, actinic, metabolic rays, i. e., blue, indigo, violet, ultraviolet (invisible). Both are esential to life, growth, and health.

The long rays have a deeper penetration than the short (the reverse of this holds true in x-rays and radium); although the short or actinic rays which are the photo-chemical rays, are concerned most with the vital processes, metabolic growth, etc. These penetrate the skin and superficial tissues, are absorbed by the capillaries and lymphatics, and partly stored in the skin itself, to be slowly absorbed later. Formaldehyde is said to be one of these skin products.

It has been shown that a physiological tan for health does not require exposure of the entire body; excellent continuous benefits are secured by exposure of less than one-half of the body surface for one hour or less.

Helio-preventoria and sanatoria for sunlight treatment exist in various parts of the world. Helio-preventoriums, Alpine schools in mountain sun, sun laboratories for children with rickets, surgical (bone) tuberculosis, etc., open-air kindergartens in the mountains, summer camps, nude cult societies in Germany and elsewhere, are the result of these studies.

An hour's exposure to direct sun rays at midday can raise the body temperature several degrees; this is also accomplished by electricity. This results in the formation of antibodies in the blood, creating defenses against disease, and increased metabolism, body nutrition. Ultraviolet causes the cells of the skin to protect their nuclei by screening with melanin, the tan. They often lower the blood pressure temporarily 5 or 10 degrees, increase the activity of the endocrine glands.

Unfortunately, it has become a popular fad to attribute fantastic powers to sunlight, ultraviolet rays, x-rays, radium, vitamines, etc., all of which are intimately related, powers which they do not possess.

Let us inquire why cod liver oil is considered a necessity in every well regulated family. The sun's influence on the liver is enlightening, important. The liver is the outstanding chemical and detoxicating laboratory and storehouse of the digestive system.

Foods, whether animal or vegetable, as stated before, are the direct biologic results of sunlight; and the portal system of veins of the intestinal canal is the transporting agent which carries these digested liquefied foods to the liver. Hence, we may consistently say that the liver chemicalizes, purifies and stores organic sunlight, is therefore a vital blood-making, toxicidal distributing organ. Thus may be explained why livers of animals and fish possess unusual medical properties, although there is a great difference in the potencies of livers in the various animals.

Vitamines are the direct and indirect products of the sun's light, and affect life above and below the earth's surface. Visible and invisible rays penetrate the earth to various depths. They also penetrate the ocean where the water is clear to a depth of about 650 feet; below this all is dark, there is no light except that produced by the deep sea inhabitants themselves; but the infra-red and ultraviolet, although invisible, continue their penetration. For this reason surface fish store up more sunlight, vitamines, than deep water fish.

The cod and the halibut live on the sea bottom and come up to the surface to greedily devour surface fish. The cod gorges itself on the little caplin and, later, on squid which live near the ocean surface and are constantly saturated with the sun's radiant energy; it then returns to its normal deep habitat. Thus the cod stores organic sunlight in its liver.

The halibut, one of the largest of the flounders or flat fish families, follows the same

law as the cod, living on the bottom of the ocean waiting for its prey. It is a cold water species, and like all flat fish has both eyes on the upper side of the head. When first hatched, however, the eyes like other fish are on opposite sides, but at an early stage, while the body is still soft and cartilaginous, the left eye gradually moves over to the side which will be uppermost and colored in the adult. This is supposed to be produced by the instinctive, continual twisting of the head so that both eyes can watch the prey above. It comes up to feed ravenously on surface fish, haddock, herring, mackerel, smelt, skate, lobster, etc.

The liver, which in the cod is enormous, in the halibut is only 1-100 of its weight, but its liver oil is 50 times richer in vitamines than the former. The liver oil seem to monopolize almost all these vitamines in these fish.

The action of the sunlight on plant life is being studied by many scientists. The enormous variety of colors in flowers alone offers endless theories and material for research. Each tiny seed, for instance, inherits the power to select from the sun's spectrum those colors which the parent possessed; the violet ray for the violet, the yellow for the proud sunflower, the red for the gorgeous Radiance rose, the blue for the Delphinium, prismatic splashes for the variable pansy, and the lavish demand on the yellow and blue rays in intimate blendings to create every shade of green, to color every blade of grass, every leaf of garden, field or forest.

The transformation of solar energy into matter, as evidenced in the case of chlorophyll, the green coloring matter of plants, has been made a special study and investigation by the U. S. Department of Agriculture, the Smithsonian Institute, Harvard University and the G. F. Kettering Foundation for the study of chlorophyll and photosynthesis.

A great uncharted field in the study of our sun, especially its influences on terrestrial changes, awaits further development. It is hoped that this brief paper will stimulate the reader to take a deper interest in the study of Nature; he shall then fathom the depth of what the Bard of Avon once wrote, that there are

"Tongues in trees, books in running brooks,
Sermons in stones, and good in everything."

DIAGNOSIS AND TREATMENT OF DISEASES OF THE TRACHEO-BRONCHIAL TREE*

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This is a very broad subject and my time is limited so I will take up only the more common diseases. Since the advent of the bronchoscope and the x-ray there are a large number of diseases of the trachea and bronchi that have been found to be more common than formerly thought. We will divide these conditions into three groups. The first group is the infectious which means an infection of the mucous membrane of the bronchi and bronchioles of long standing, such as bronchiectasis. Naturally this diagnosis is easily made by means of the amount of sputum, odor, and by an opaque substance being injected into the trachea followed by an x-ray picture. This will show large dilated bronchi and sacculated areas. In such cases great success has been made with the use of the bronchoscope by washing out the sacculated areas with a weak solution of iodine or potassium permanganate and the use of suction, thereby removing all mucus and pus from these areas; also by the use of the high frequency current cutting through these sacks, opening them completely. This treatment it kept up over a period of time, has shown wonderful results in the amount of discharge secured and the generally improved condition of the patient.

Another type is the infection of one or more bronchi by the damming back of the secretions caused by a stenosis of the bronchi. This causes a large amount of pus and blood to be expectorated. The diagnosis is easily made in these cases; clouding in the x-ray is easily seen. Also, such infection can be determined by the character of the sputum, which is usually streaked with blood and contains numerous organisms which are often found to be Spirillum, staphylococcus, streptococcus and pneumococcus. Patients suffering from this type of disease usually run a slightly elevated temperature, are always underweight, tire very easily and are of low vitality.

Bronchoscopic examination will reveal a bronchus discharging pus into the larger

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communicating bronchus, also a stricture of the bronchi. The treatment is dilatation of the stricture, suction of all debris from this portion of the lung, and irrigation with some weak antiseptic. This is done in conjunction with the use of tartar emetic intravenously and neosalvarsan, provided Spirilla of any description are found.

Lung abscesses cannot be taken up under this heading except those cases in which an abscess of the lung has opened into a bronchus. Marked success has been obtained by irrigating with a weak solution of iodine or potassium permanganate.

In the second group we have the tumors, benign and malignant. The most common of these are: papilloma, endothelioma, and sarcoma. The diagnosis is easily made by the use of the bronchoscope and x-ray. In benign tumors the use of radium needles and x-ray are of great benefit. In papilloma of the larynx and bronchial tubes, I have found the use of the high frequency current, which is a late method, is the best way of removal.

Naturally, the malignant conditions are not as easily handled. However, where the tumor is pedunculated and causing an obstruction to the breathing, it is best that the pedunculated area be removed by use of the cutting knife of the high frequency current through the bronchoscope. After this, deep therapy x-ray should be used and in some cases the patient will survive for a period of two or three years. However, the treatment of malignant conditions of the bronchi and larynx are not very encouraging. Sooner or later the patient will have a severe hemorrhage or metastases to other organs which will cause death.

In malignant conditions of the larynx laryngostomy is advisable if there has been no metastasis. We seldom see these cases in the South until there has been metastasis, in which event tracheotomy is advisable. The diagnosis of malignant conditions of the larynx is made upon the duration of the disease, appearance and character of the lesion, and the readiness with which it bleeds when touched. Malignant conditions must be differentiated from a syphilitic larynx and in this case the differentiation is easily made by the use of the Wassermann test. A syphilitic larynx never causes pain and seldom bleeds. Malignant conditions must also be differentiated from tuberculous conditions. Tuberculosis of the larynx is always secondary to a pulmonary condition which is of long standing. These patients always run high temperatures and have all the physical findings and symptoms of other tuberculous patients. The lesion in the larynx usually starts in the anterior commissure between the vocal cords and extends over the vocal cords causing an edema of the arytenoid cartilages. The ulcer is denuded at first, the entirety of the mucous membrane later involved with destruction of the vocal cords, causing an edema of the epiglottis. The edema of the arytenoids is usually pathognomonic of tuberculous laryngitis. The ulcer of the condition is always very painful and never bleeds. We will not go into the discussion of the treatment at this time as there are a number of theories as to the handling of these cases. However, it has been my experience that the physical condition of the patient has more to do with the end result than anything else.

The third group, varicose veins of the bronchi, is very common. I have seen several cases in which the vein completely occluded the bronchi and at times there would be an erosion of the vein in which severe hemorrhage followed until the patient was exsanguinated. These patients are completely cured by using the coagulation current of the high frequency machine through the bronchoscope, entirely eradicating the vein. It must be remembered that there is danger of an explosion of the lung if ether is used as an anesthesia. There are a number of cases on record where this has happened. Let me impress upon you that this condition can be diagnosed only by the use of the bronchoscope.

Foreign bodies of the trachea and bronchi are very common and should either condition be suspected, it is wise to go thoroughly into the history of the case. First there is almost invariably a history of a coughing spell with the patient turning blue and then afterwards an occasional cough with a wheeze if the foreign body is lodged in either of the bronchi and has become fixed. If the body completely occludes the bronchus there will be an absence of breath sounds on the side affected and an emphysema on the opposite side. Bodies found in the trachea usually cause the most cyanosis and are the most dangerous at the time. If they should become dislodged and

get caught between the vocal cords, instant death occurs from spasm of cords.

The most common symptoms of foreign bodies are cyanosis, dyspnea, irritability, wheezing, cough and elevated temperature. The peanut is the body most dreaded as the vegetable oil in the outside husk of the kernel causes a severe irritation in the mucous membrane of the bronchial tree and causes death within a short time from pneumonia. In all cases where there is an expected foreign body, it is best to do a diagnostic bronchoscopy as in many cases where there is but slight or no physical signs or symptoms, a foreign body will be found.

It is needless for me to say that x-ray examinations in all these cases should be made to determine the location and the nature of the body and the best method of removal. There are two schools of thought as to the method of removal. One is that of Lynch of New Orleans and in his teachings he advocates the Lynch Suspension apparatus and complete anesthesia with ether. The other is taught by Jackson of Philadelphia in which he does not use any anesthesia whatever. However, in later anesthesia I have found that avertin has worked with marked success and saves the patient a great deal of discomfort with little liability of pneumonia and certainly with less trauma than without the use of any anesthesia whatever.

Certain precautions should be observed in removing foreign bodies from the lung. First, the patient's head must be properly held. Second, the bronchoscope should not be of too large a caliber because it will cause edema of the larynx. In case of edema, it is necessary to do a tracheotomy immediately. One other danger I have found is that of untrained men doing bronchoscopies. Mortality and morbidity of bronchoscopy vary directly with the degree of skill and experience of the operator and the conditions for which the endoscopies are performed. The simple insertion of the bronchoscope is devoid of harm if carefully done. The danger lies in repeating bronchoscopies at too frequent intervals, or in prolonging the procedure unduly. In children under one year of age, endoscopy should be limited to twenty minutes, and should not be repeated sooner than one week, unless urgently indicated. Little or no reaction follows short careful endoscopies.

Before closing I wish to call your attention to a common injury of the larynx and that is fracture, which seems to be rather common. I have had three cases under my care during the past year. The treatment used in these cases is ice packs and opiates for the pain and in case of emphysema of the surrounding tissues external to the larynx, it is best to do a tracheotomy immediately before the edema and emphysema extends into the inside of the larynx and causes obstruction.

THE TREATMENT OF BURNS*

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This paper deals chiefly with the modern treatment of burns, thus in so brief a paper it will be impossible to go into detail concerning the physiology, chemistry and pathology of this condition. It is necessary, however, to have some general understanding as to the etiology of the toxemia in this condition in order to give a rational form of treatment.

The literature for many years has been full of controversy over this question, but Aldrich[1], in 1933, was the first to suggest infection as being the cause of toxemia in burns. Aldrich based his theory on careful bacteriological study of burned patients, making cultures on the burned areas from the time of admission until areas were healed. He found the wounds to be sterile during the first twelve hours but that after twelve hours had elapsed, culture showed mixed infection, and in forty-eight to fifty-six hours, pure cultures of streptococcus could be obtained. The period of toxemia with the usual symptoms of restlessness, nausea, pain and elevation of temperature begins from the fifteenth to eighteenth hour and Aldrich found that this syndrome ran right along with the beginning of infection as shown by his studies.

When one stops to consider this he is in somewhat of a quandary as to why we should become alarmed about broken down proteins when we have something as concrete as bacterial infection as an etiological factor in the toxemia of burns. If a burn is toxic because of infection, then why should we not treat it as such, rather than by applying lard, grease,

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wax or some other similar concoction which helps to form a good culture medium for infection instead of combating it.

The initial shock in burns is an entity within itself and similar to any other surgical shock. The treatment for shock should be initiated as soon as the patient is seen regardless of what form of therapy is to be used on the burned area. This treatment consists of large amounts of fluid, chiefly saline, glucose, or whole blood. Probably the best form of fluid is whole blood, but saline or glucose will suffice if given in sufficient amounts to maintain or restore the blood pressure level. Sedatives and warmth are also necessary adjuncts to fluid in the treatment of early shock. Burned patients usually either rally from the shock within a few hours or become moribund, and when they have rallied, then burn therapy may be instituted.

The general treatment of burns should consist of a high vitamin and high caloric diet, and fluid intake should be at least 3500-4000 cc. a day. Regardless of what form of specific treatment is used, it is necessary to keep the patient warm and this can best be done by the use of a heat cradle. The severity of the burn determines the type of treatment which should be used. Calamine lotion is very soothing to first degree burns and is usually all that is necessary, as this group includes only the cases with skin erythema, such as sunburn. In minor second and third degree cases, a mixture of radolatum oil, butesin, picrate or gentian violet jelly give good results, but are not adequate for severe cases. In severe second and third degree burns there are three methods of treatment which I consider worthy of mention, namely: tannic acid, gentian violet and hypertonic saline baths.

Tannic acid has received a great deal of recognition within the past year, although it was developed by Davidson[2] in 1925. Davidson advocates the use of a 2½ to 5% solution of freshly prepared tannic acid applied every twenty minutes until an eschar is formed. It may be applied either as a spray or with gauze compresses saturated with the solution. The advantages of this form of treatment are that tannic acid is soothing to the burned area, is slightly germicidal, prevents loss of fluid, and tends to minimize infection by sealing over a sterile field. The disadvantages are that the eschar is brittle and tends to crack; it tends to masque underlying infection, and probably destroys the minute islands of unburned epithelium.

Gentian violet was first advocated by Aldrich in 1933 and has merits which demand mention. The burned area is sprayed with a 1% aqueous solution of gentian violet every two hours until an eschar is formed and thereafter every four to six hours as needed. When infection begins the eschar will soften and it is then necessary to pick the soft area off and re-apply the solution until a new eschar has formed. The advantages of gentian violet are that it is soothing, is germicidal, and if watched closely the patient will not have as toxic a convalescence as with tannic acid. The disadvantages are that it stains the bed linen, requires absolute relentless supervision, and is consequently not very practicable for the general practitioner.

The hypertonic saline bath treatment of burns was first advocated by Blair, et al. in 1932 and consists of a tried and tested method of combating infection by using hot soaks or compresses. The technique consists of placing the burned patient in a tub of warm salt solution two or three times daily and allowing him to remain in the tub from forty-five minutes to one hour at each sitting. The solution is made up in the tub and should be made to about a 3 to 5% strength in ordinary unsterile tap water. It is advisable to give a sedative prior to the first two or three baths, but after that the patient undergoes no discomfort whatsoever. When out of the bath, he is kept in bed without dressings, under a warm tent heated by electric light globes. Where the burn involves the face it is advisable to use normal saline compresses over this area and the tub baths may be instituted for the rest of the body. This form of treatment does not completely eliminate infection but the infection is held in check at all times and the patient does not run an extremely toxic course, as is the case in most forms of treatment.

Regardless of which form of treatment is used the patient should be watched carefully and treatment should be under the physician's personal supervision. Frequent blood counts are important as I have seen two burned patients die of agranulocytosis, which no doubt was a result of the severe infection, and it may be justly assumed that there have been

more deaths from this complication than we suspect. The sedimentation rate is very helpful in checking the onset and degree of infection. It is possible, by this simple test, to predict a rise in temperature at least twelve hours prior to its onset.

In conclusion, I wish to emphasize the point that we need not trouble ourselves about the hypothetical theories of burn toxemia when we have a basis for toxemia as concrete as infection. Why not treat a burn as though it were an infected wound and not some freak condition that baffles the philosophers?

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ATYPICAL SYMPTOMS OF MALARIA*

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Only because I wish to create a discussion upon this subject of malaria and its various symptoms do I bring this paper before you today. The title is simple in itself but the various and insidious ways in which the disease manifests itself make the subject complex and thereby a most interesting condition for study.

It has been said that syphilis simulates every disease to which man is heir. The same can be said about malaria. It is a disease that has as its symptoms chills and fever which are considered by medical men to be the typical and almost pathognomonic symptoms of the condition. However, it can be said with no fear of contradiction, that the disease is manifested in only about three to five per cent of the cases by the so-called typical chills and fever. Due to this fact, our professors in medical school axiomatically beseeched us students, over and over again, to, "when in doubt, give quinine." I may add that this one axiom has delivered me many times out of a most puzzling dilemma and has taught me most impressively what I am attempting to bring to you today.

To illustrate this, I wish to present a few of many puzzling cases.

Case 1. Mr. L. R., white, age 46. History was negative with exception of a severe injury to pelvis when young which became infected, necessitating incision and curettage of the pelvic bone. He remained well for about 22 years when this injury began to be sore and swell. He was seen by me December 4, 1927 with marked swelling both behind and in front of the old injury and a diagnosis was made of psoas abscess. It was very large with much pain and the patient's temperature ranged from 102.3° to 104.3.° He was assured that when the abscess drained the pain would cease. December 8, the abscess was drained of about one quart of pus through the indicated incision. Naturally the patient was told that he would be relieved of his excruciating pain at once and he would get some much needed sleep. To my surprise, when I saw the patient next day, his pain was even worse and the fever was still as high as ever. After giving ample time for the fever and pain to abate, he was started upon large doses of quinine on December 12. In 18 hours all pain had ceased and the fever cleared in about 36 hours. He had no more fever or pain even though he had much drainage and swelling for several days. Ten months later he began having severe pain in the same side but no swelling or fever. He was very much excited for fear his side was going to abscess again but, immediately upon giving large doses of quinine, all pain ceased as if by magic and he has remained well for 8 years.

Case 2. Mrs. G. R., white, age 39 had been in a state of cachexia for several years. In March, 1935, she began to have severe pain in left mastoid region. The pain was excruciating in degree to the extent that only a very strong narcotic would furnish any relief. She ran the gamut of doctors in her town until one suggested, to the disgrace of the medical profession, that "it might be due to a *pinched*

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nerve and, if so, she had better go to a chiropractor"; that he himself, "knew nothing about that." She took his advice and, when the chiropractor began to hurt her so badly that she had to be carried from his office by friends, she quit his treatment in desperation. She had had no fever—in fact, her temperature was subnormal all the while and the blood examinations were reported negative upon two occasions. However, on large doses of quinine, her condition immediately cleared up. After three weeks, pain again developed in the same side with severe chills and fever. After another course of quinine followed by plasmochin, she remained free of symptoms and gained weight so fast that—quoting her—"people ask me so much about my improvement that I become embarrassed." About seven months later she came to me saying she believed her "old condition" was coming back and wanted another treatment. It was given and she has remained well ever since.

Quite a number of women, 4 to 12 days post-partum who had excruciating pains in the lower abdomen and back with a temperature of from 102° to 104°, have come under my observation. These facts suggested septic infection, but large doses of quinine ended the pain as if by magic and the temperature returned to normal in from two to five days.

Many cases of gonorrheal urethritis where pain is the salient feature, also pain in pyelitis and cystitis, have been made more amenable to analgesics by cinchonizing the patient sufficiently.

Of all the neurological manifestations of malaria, coma is probably the most common. The onset of coma may be as sudden as an apoplectic stroke, whence came the old phrase, "intermittens apoplectica." An article by Dr. Carrol C. Turner, professor of Neurology and Psychiatry, University of Tennessee, College of Medicine, states: "Among the modern authors De Silva refers to the 'stroke in malaria'. More commonly the onset of coma is gradual with such preceding symptoms as headaches, apathy, somnolence, agitation and melancholia. It may last a variable length of time, usually from one to four days. Frequently the recovery from coma is as sudden as the onset, but more usually it is gradual to be followed by bradypsychia, confusion and somnolence. The coma is usually punctuated by convulsions of generalized type. The limbs are usually limp and the tendon reflexes are depressed and, not uncommonly, such irritative motor phenomena as twitching of the muscles of the extremities and face are present. When spastic phenomena are present, the tendon may be normal or exaggerated, accompanied by pathological toe phenomena to plantar stimulation." Nothnagel refers to the persistence of the diminution of the abdominal reflexes in cerebral malaria. Focal disease of the brain, because malaria does tend to localize itself in the brain at times, may persist after recovery from coma, leaving residues as hemiplegia, aphasia, and rarely monoplegia. In some cases all symptoms disappear with recovery from coma. In others they may persist for variable lengths of time.

Case 3. Mr. C. A. C., white, age 60, became comatose and was sent to the city hospital. When I was called he was irrational and in complete coma part of the time. Temperature was 98° and remained subnormal during his entire stay in the hospital of 10 days. We held him under observation for five days when we concluded that malaria was the cause of his condition. When large doses of quinine were given every six hours through the 24 hours for 4 days, be became normal and on the tenth day was discharged. The medication was stopped for obvious reasons and in about three weeks he again became comatose and this time had severe chills and fever of 105°. Upon the reinstitution of large doses of quinine by mouth for one month his condition returned to normal and has remained so for about five years.

The former were cases of mine but I wish to give you a few of the more illustrative points shown by four cases reported by Professor Turner whom I have previously quoted in this article.

"Case 1. Negro male, age 27, admitted to the Memphis General Hospital July 22, 1931 and died July 26. While working in field, patient fell. From then on he remained in a stuporous condition with a temperature ranging from 98° to 103.4°. No malaria organisms were found in any blood smear. Autopsy was negative except for the spleen which was very much enlarged, bulging over cut edges and smears taken from spleen pulp showed large numbers of crescents of estivoautumnal malaria.

"Case 2. White boy three years of age, admitted to hospital October 5, 1933 and died October 6. The blood was positive for estivoautumnal malaria. Neck was stiff, Babinski, Brudzinski and Kernig were all positive. Autopsy was negative except for very large spleen and a few petechial hemorrhages in many organs and especially the brain, together with a few simple hemorrhages between the pia mater and cortex, with no exudate present.

"Case 3. White boy 10 years of age, was admitted to hospital in 1924 with paraplegia. While fishing he 'fell asleep' on the stream bank. He awoke with a severe headache and found that he could not use his legs. He showed many positive signs of neurological conditions. Next day he developed a hard chill and temperature of 104° when the blood was filled with tertian and estivoautumnal parasites. He had to be catheterized. With large doses of quinine he voided on the fifth day and could walk unassisted by the tenth day.

"Case 4. Mrs. A. C. W., white, age 50 was admitted to hospital September 17, 1935. Two weeks previously she exhibited some confusion, wandered about house aimlessly, once got out of bed and went out of house in nightgown. She had several spells of sobbing for which she could give no reason and was extremely depressed. She complained of almost continual headache and inability to sleep. At one time her husband awakened and found her bending over him with wide staring eyes. She said frequently that voices were urging her to kill herself. On admission to hospital she was uncommunicative, refused to eat and was indifferent to bladder and rectal functions, twice voiding in bed. She walked most of the nights in hospital, crying, throwing dishes off tray, knocking the furniture about the room and trying to get out of her window repeating she didn't do it and 'they are calling out to me to end it all.' Rectal sedation had to be resorted to for 48 hours. The family history was negative except for repeated attacks at malaria for several summers, but malaria during past summer was denied. She had passed menopause eight years previously in a perfectly normal way. The temperature and pulse were normal on admission to hospital and did not vary perceptibly from normal during her whole hospitalization. Blood smears were repeatedly negative for malaria. For a week she was completely disoriented and amnesic. She was depressed, worried and believed her husband dead.

"Examination revealed a large palpable spleen. With this indefinite, though suggestive finding she was given nitroglycerine followed by a thorough search for malaria on several smears. The same was done after 0.5 cc. of 1:5000 epinephrin subcutaneously but all were negative. In spite of all negative findings, large doses of quinine were started with a noticeable improvement from the start and by the third day she was cooperative and began to take an interest in her surroundings. Her confusion disappeared like mist and with the depression lifted she heard no more voices.

"The subsequent observations reveal that she is gaining weight and following her usual household duties and personal interests normally. Her red cell count had increased in two weeks from 3,370,000 to 4,200,000."

SUMMARY

I wish to emphasize in this paper that we must not let our diagnoses rest upon negative blood smears. We must get acquainted with malaria so that we won't have to rely upon a blood smear but make our diagnosis upon its clinical manifestations even though they are atypical.

An additional purpose of this paper is to draw attention to a group of conditions which we are prone to overlook in malaria, by discrediting the potentialities of this infection. The malaria plasmodium is a neurotropic organism producing a well patterned neurological and psychiatric disease syndrome. Quinine many times will cut short or abort the course of a psychosis, especially where there is marked secondary anemia with palpable spleen.

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COOPERATION

The term "cooperation" is familiar to every member of the State Association but for years has meant very little to many. Now is the time, with the splendid start made by the State Association in employing a full time managing director, to see that all the cooperation is given him that is humanly possible. The district meetings which are being planned and held should give him the medium to know each member of the Association much better.

Understanding, as we know, smoothes out many difficulties and corrects many supposed faults of any organization. The different districts should realize these meetings are their meetings and all the items of business pertaining to the State Association should be threshed out with the managing director at that time, because he will be able to get a cross-section of our needs and perhaps have many helpful suggestions to offer on how they can be corrected.

A united State Association can go forward by leaps and bounds, but a divided one will fall prey to every organized group or cult in the State. Each individual member can help build the Association into a united whole by, first, giving his whole-hearted cooperation and assistance in matters of vital importance to organized medicine; second, being friendly with allied groups such as dentists, pharmacists, and nurses, whose aid is needed; and, third, working toward increasing the activities of his component society so that every society will be on guard at all times to do its bit as an organized group. Lastly, every office holder, from the highest to the lowest, should be thoroughly acquainted with the needs of the State Association so that he will be willing, knowing full well the aims of our Association, to lend his aid. The result? Success and the things we need for the protection of the public and organized medicine.

TO AMERICA'S SCHOOLS—*YOUR HEALTH!*

Once more. during the coming fall, winter and spring, the Voices of Medicine will salute the people of America, with the toast *"Your Health."* This is the well-known title of the radio program of the American Medical Association and the National Broadcasting Company. The coming season will be the fifth; the first two years were devoted to health talks, and the last two seasons to dramatized health messages. This year, the salutation will be addressed particularly to the teachers and students in the Junior and Senior high schools, in the hope that the program will be helpful in illustrating, amplifying, and enriching the health teaching in those schools. The program will be on the air while schools are in session, so that the program may be utilized directly in the thousands of schools which now have or soon will have radio and public address systems reaching the class-rooms. Programs will be announced in advance in *Hygeia,* The Health Magazine. While the program is planned especially for high schools, it will not sacrifice the interest which it has held for listeners in the home. To teachers, students and stay-at-homes, the American Medical Association and the National Broadcasting Company will address their message of health education with the familiar musical theme "Hale and Hearty," written especially for the program, and the toast, "To America's Schools, *Your Health!*"

Southeast District Annual Meeting

The first annual meeting in the Southeast Committee District (F) was held Friday, September 3 at 6 p. m. in the Columbus Hotel, Miami. The attendance was unusually good, considering the time of year this meeting was held. Quite a number of doctors were still on their vacations which naturally affected the attendance. However, by the registration list following this article, it is plain to be seen that a fine representation of medical men got together at this district meeting. There was a total registration of 95. Of this number, 67 were members of the district; 3 were members of the Florida Medical Association residing outside this particular district; 4 were visitors; and 21 were members of the Woman's Auxiliary and lady guests. The officials of the Columbus Hotel served a very fine dinner to the doctors, guests and their wives. The dining room is beautiful and was tastefully decorated. The food and service were a real feature. Following the dinner the meeting was called to order by Senior Councilor, Dr. F. K. Herpel, at 8:10 p. m. Dr. Herpel in a few well-chosen words, outlined the purpose of the annual meetings of the six districts of the Association and referred to the cooperation of the various officers of the organization.

The address of welcome was given by Dr. Reuben N. Burch, President of the Dade County Medical Society. Dr. Edward Jelks, President of the Association, was then called upon as the first speaker of the officers. Doctor Jelks responded to the address of welcome and then in a very interesting manner outlined some of the activities of the Association. Doctor Jelks referred to the work and responsibility of the officers and took up briefly some of the activities of the councilors and various committees. Dr. Shaler Richardson, Secretary-Treasurer and Editor of the Journal, was then heard and gave a very interesting outline of the details and activities in connection with his offices, stressing in particular the Association's Journal. Dr. Homer Pearson, a past president of the State Association, was then recognized, as well as the managing director, Stewart Thompson.

The gavel was then turned over to Dr. H. A. Walker, Junior Councilor, who presided during the scientific session. At 8:50 p. m. the first paper was presented by Dr. Lloyd J. Netto of West Palm Beach. The subject of this paper was "Ectopic Pregnancy." On account of the unavoidable absence of Dr. Kenneth Phillips, his paper on "Resume of Fever Therapy" was read by Dr. Homer Pearson. The last paper was by Dr. Shaler Richardson on "Treatment of Retinal Detachment."

Doctor Walker then opened the meeting for a discussion of the three papers and a number of doctors present took part in the discussion. The meeting adjourned at 9:55 p. m.

A number of informal meetings were held with various officers and members of the Dade County Medical Society, in connection with the selection of a hotel as headquarters for the annual meeting of the Florida Medical Association and the time most suitable for this meeting. A survey of the hotels had previously been made by your managing director and the report was analyzed together with communications from various hotels at the informal gatherings. The entire matter was thoroughly discussed as to the most acceptable location in Miami for the majority of the members and the date which is most acceptable to the general membership. Since these meetings were primarily for information and those present were not acting in an official capacity, the entire matter was left for official action of the Dade County Medical Society as a recommendation to the Executive Committee.

The Dade County Medical Society, as host of the district meeting, carried everything off with its usual efficiency. The local committee on arrangements looked after the interests of the guests in a most acceptable manner. It was a real privilege to attend this meeting and everyone present expressed by his attitude, a deep appreciation for the very pleasant and constructive meeting in this district.

REGISTRATION

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Walker, Harrison A., *Junior Councilor*...Miami Beach
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Jelks, Edward.....Jacksonville
Netto, L. J.....West Palm Beach
Richardson, Shaler.....Jacksonville

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* * *

South Central District (E)

The first annual meeting of the South Central Committee District (E) will be held at Melbourne, Thursday, October 21 at 3 p. m. at the Golf and Country Club. All members of the Florida Medical Association residing in this district are urged to attend. The officers of the Florida Medical Association have arranged to attend this meeting and you will, therefore, have an opportunity to meet and hear them. The annual meeting in this district is sponsored by the councilors with the cooperation of the secretaries of the component societies and they have arranged the following program:

W. C. Page, *Senior Councilor*
H. D. Clark, *Junior Councilor*
Stewart Thompson, *Managing Director*

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Douglas G. Scott ..... Sanford

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I. M. Hay, *Chairman*
I. F. Bean

FIRST GENERAL SESSION

THURSDAY, OCTOBER 21, 3 p. m.
GOLF AND COUNTRY CLUB

Call to Order—
W. C. Page, *Senior Councilor*

Address of Welcome—
I. M. Hay, *Chairman*
Local Committee on Arrangements

Brief Addresses by State Officers—
Edward Jelks, *President*
Shaler Richardson, *Secretary-Treasurer*
W. McL. Shaw, *Chairman of Council*

Recognition of: Committee Chairmen
Past Presidents

Announcements

SCIENTIFIC SESSION

Presiding, H. D. Clark, *Junior Councilor*

4:30 p. m.—"Abnormal Bleeding in the Middle-Aged Woman"
C. J. Collins, Orlando

4:45 p. m.—Discussion

5:00 p. m.—"Common Skin Diseases in General Practice"
E. W. Potthoff, Titusville

5:15 p. m.—Discussion

5:30 p. m.—"Bone Injuries in General Practice"
E. L. Jewett, Orlando

5:45 p. m.—Discussion

Adjournment

STATE NEWS ITEMS

Dr. Maurice Zimmerman who has been spending some time at Saratoga, N. Y. announces his return to Miami Beach where he has reopened offices at 630 Lincoln Road.

* * *

Dr. William D. Lithgow of Miami recently returned from his vacation, part of which was spent at the New England Music Camp at Oakland, Me. He also spent some time doing postgraduate work at the Postgraduate Hospital, Columbia University.

* * *

Dr. and Mrs. D. G. Scott of Sanford announce the birth of a daughter, Mary Gertrude, January 4, 1937. Doctor Scott is secretary of the Seminole County Medical Society.

* * *

Dr. and Mrs. S. A. Shoemaker returned recently from a seven weeks' trip through the North which combined business, pleasure and professional interests. Doctor Shoemaker gave attention to their property interests in Bluffton, Indiana and vicinity while Mrs. Shoemaker visited relatives at Muncie and Selma, Ind. They also visited their daughter and family, Dr. and Mrs. G. H. Ayres, in Northampton, Mass. Doctor Shoemaker also devoted some time to clinical observation in a prominent New England hospital.

* * *

The many friends of Dr. J. T. Denton of Sanford extend their sympathy in the death of his wife on August 17. Doctor Denton is a past president of the Seminole County Medical Society.

* * *

Dr. D. W. Harris is now located at Ft. Lauderdale and will limit his practice to urology. Doctor Harris was formerly located in Miami.

* * *

Dr. A. M. Sample of Ft. Pierce sailed from New York September 1 for a month's postgraduate work in Vienna. He expects to return home about the first of November.

* * *

The many friends of Dr. Jack Halton will be glad to learn that he has fully recovered from his illness of two years' duration and has resumed his proctologic practice in Sarasota. His offices are in the Commercial Court Building.

The first annual meeting in the North Central Committee District (B) will be held at Ocala, Wednesday, October 27. The program and more complete information will be shown in next month's Journal.

* * *

The first annual meeting in the Southwest Committee District (D) will be held Thursday, November 11 at Plant City. The date and place of the meeting have been arranged by the councilors and secretaries of the component societies in the district. Watch your next month's Journal for more complete information.

* * *

Please note inside back cover for complete schedule of meeting dates for the six districts of the State Association.

* * *

Dr. Marvin Smith and family of Miami have returned from a six weeks' visit to New York and Canada.

* * *

The Fifteenth Annual Meeting of the Academy of Physical Medicine will be held at the Hotel Walton, Philadelphia, October 19-21, 1937. The Academy, which is international in scope, will present a scientific program based on reports of the most recent research and practice of the various specialties. In addition to the lectures, demonstration clinics will be held at the hospitals of the University of Pennsylvania, Jefferson Medical College, and Temple University. A copy of the program may be had by addressing William D. McFee, M. D., 41 Bay State Road, Boston, Mass.

* * *

The Florida Dermatological Society will hold its regular quarterly meeting October 24 at Tampa. President Chadbourne Andrews will preside.

* * *

Dr. and Mrs. A. J. Logie of Jacksonville announce the birth of a son, Arthur J., II, in St. Vincent's Hospital, September 1.

* * *

Dr. and Mrs. J. J. Guerra of Tampa have returned from a vacation trip through Mexico and Texas.

Dr. Warren Quillian and family of Coral Gables spent their vacation at Lake Junaluska, N. C. during the month of August. Mrs. John Wiley Quillian of Miami, Doctor Quillian's mother, donated a silver loving cup for a family golf tournament. Doctor Quillian has five brothers, four of whom have been competing with him for several years in golf. Claude B. Quillian is superintendent of schools at Bradenton, Florida; Hubert T. Quillian is vice-president of Shorter College, Rome, Georgia; Dr. Paul W. Quillian is pastor of the First Methodist Church of Houston, Texas; Ralph Quillian is an attorney at Atlanta, Georgia; and Guy R. Quillian is a druggist in Miami, Florida.

The Quillian brothers are natives of Georgia. This is the third year they have competed for the loving cup. In 1935 the cup was won by Dr. Warren Quillian of Coral Gables and Hubert Quillian won it in 1934. After a brotherly struggle over several golf courses around Asheville, the cup was won by Dr. Paul Quillian of Houston, Texas, this summer.

* * *

Dr. Joseph Halton is spending the month of September in New York, where he is doing postgraduate work in cancer at the Memorial Hospital.

* * * *

Dr. Thomas C. Thompson, a resident of Jacksonville for thirty-five years, died at his home in Chaseville on August 31. Doctor Thompson retired from practice several years ago because of failing health.

* * *

Dr. and Mrs. E. E. Strickland of Mt. Dora announce the birth of an eight pound son, Lex Hannum, July 1, at the Lake County Medical Center, Umatilla.

* * *

Dr. J. W. Brantley, son of Dr. and Mrs. Z. Brantley of Grandin, graduated in medicine from Tulane University on June 9, 1937. He has successfully passed the examinations of the Louisiana and Florida State Boards and is now serving his internship in St. Luke's Hospital, Jacksonville.

* * *

The many friends of Dr. Lucille Johnson Marsh of Miami will regret to learn of the death of her father, Dr. P. T. Johnson of Erie, Pennsylvania, on August 3.

Dr. Raymond H. Ralston of Lakeland and Miss Ruby Mae Fennell of Ambridge, Pa. were married on July 19.

* * *

Dr. and Mrs. D. Ward White of Miami Beach spent a month's vacation in Havana and Mexico City. They plan to leave the middle of September for White Sulphur Springs and New York to be away another month.

* * *

Dr. and Mrs. Frank T. Barker of Tampa are in Chicago where Doctor Barker is taking postgraduate work in traumatic surgery and fractures at the Cook County Hospital. He will do further work along the same lines in New York before returning to Florida.

* * *

Dr. J. B. Davis of Daytona Beach announces the removal of his offices to 208 Magnolia Avenue.

* * *

Dr. J. C. McSween, president of the Escambia County Medical Society, and Mrs. McSween, Pensacola, recently spent a two weeks' vacation visiting friends in Houston, Texas, and Mexico City.

* * *

Dr. and Mrs. W. M. Rowlett of Tampa are spending the month of September in New Hampshire.

* * *

Dr. Clarence D. Rollins of Jacksonville spent some time during August at Myrtle Beach, S. C.

* * *

Dr. and Mrs. Harrison G. Palmer of St. Petersburg are spending a two months' vacation in Detroit and other parts of Michigan.

* * *

Dr. and Mrs. John C. Branham of Miami Beach have returned from a vacation spent in Virginia, Washington and New York.

* * *

Dr. and Mrs. Luther Holloway of Jacksonville announce the birth of a son, Charles Covert, Monday, August 9 in St. Vincent's Hospital.

* * *

Dr. Ludo von Meysenbug of Daytona Beach and Miss Amelia Aldige of New Orleans were married last February 27.

* * *

Dr. A. M. Melvin of Miami announces the removal of his offices to 127 N. E. 5th Street.

Dr. R. B. Stritzinger of Pensacola announces the removal of his offices to the Blount Building.

* * *

Dr. A. K. Wilson of Jacksonville spent the first two weeks of August at Highlands, N. C.

* * *

Dr. and Mrs. Ralph Russell of Ocala have returned from a three weeks' cruise of the Caribbean Sea, visiting several Central American countries.

* * *

Dr. and Mrs. H. Foxworth Horne and children, Foxworth Jr., and Marcelle, of Jacksonville left early in August by motor for a vacation in California. They visited many places of interest enroute and returned early in September.

* * *

Dr. F. D. Pierce is now located at 420 Sweet Building, Ft. Lauderdale. Doctor Pierce was formerly located at Miami Beach.

* * *

Dr. C. Larimore Perry of Miami made a trip to New York City for study in the city hospitals there. Doctor Perry also will attend the meeting of the Residents of the Mayo Clinic in October and the American College of Surgeons meeting in Chicago.

* * *

Dr. P. H. Guinand of Clearwater announces the removal of his offices to the Coachman Building.

* * *

Dr. Louis M. Orr, II, of Orlando, is acting as preceptor in urology for a period of one year to Dr. Edward M. Honke of the Graduate School of Medicine, University of Pennsylvania.

* * *

Dr. and Mrs. W. T. Simpson of Winter Haven recently returned from a two months' clinical tour of Europe. The tour was directed by Dr. Conrad Gale of New York City. Clinics were prepared for the party at Dublin, Glasgow, Edinburgh, London, Stockholm, Copenhagen, Berlin, Carlsbad, Zourik (Switzerland) and in Paris. Dr. and Mrs. Simpson report a most enjoyable and profitable trip.

Dr. W. M. Rowlett, Secretary of the Florida State Board of Medical Examiners, reports that one hundred and twenty-one out of one hundred and forty-four physicians who took the written examination held in Jacksonville, June 14-15, 1937 have been licensed to practice medicine in Florida. As usual there were several outstanding physicians who took the examination; the most prominent being Dr. James S. McLester, Retiring President of the American Medical Association and Dr. Verne A. Dodd, Professor of Surgery at the University of Ohio. The following names and addresses are those of the successful applicants:

Samuel Henderson Adams, Tampa
Egbert V. Anderson, Jacksonville
Laurie James Arnold, Jr., Lake City
Jacob Morris Aronson, Chicago, Ill.
Henry Jennings Babers, Jr., Gainesville
Eugene Manigault Baker, Chattahoochee
Everett Nathaniel Bennett, Kokomo, Ind.
Theodore Martin Berman, Miami Beach
William Herrick Bernstein, New York City
Robert Lowry Berry, Jr., Villa Rica, Ga.
Otto Schindler Blum, Albany, Wisc.
Clyde Findley Bowie, Marianna
James Worth Brantley, Grandin
Carl Gustave Braunlin, Portsmouth, O.
Walter Albert Braunlin, Portsmouth, O.
Thomas Fort Bridges, Nashville, Tenn.
Otis Winfield Britt, Chattahoochee
Bert R. Burgoyne, Monroe, La.
Thomas Cecil Butt, Orlando
James Joseph Callahan, Oak Park, Ill.
Hugh Alfred Carithers, Jr., Winder, Ga.
Benjamin Coleman, Miami
Miles Arnold Collier, Bartow
Benjamin Franklin Croutch, Chicago, Ill.
Jackson Bernard Dismukes, Haines City
William Lamar Dobes, Chattanooga, Tenn.
Verne Adams Dodd, Columbus, O.
Elwyn Evans, Chicago, Ill.
Jack Jacob Falk, Long Island City, N. Y.
Charles Lafayette Farrington, New Orleans, La.
Roland Frederick Fisher, Ft. Lauderdale
William O'Kelly Fowler, Greensboro, N. C.
Gladstone Edwin Francisco, Miami
Milton Tacitus Gaillard, Baldwin, N. Y.
Jack Galin, Hosford
George Hampton Garmany, Chattahoochee
Isbin Sylvester Giddens, Ray City, Ga.
Alphonse Louis Girardin, Jr., Valdosta, Ga.
Charles Stedman Glisson, Jr., Hawkinsville, Ga.
Hugh Bascom Goodwin, Jr., Moulton, Ala.
Orien Thomas Gower, Jr., Cordele, Ga.
Hiram Phillip Hampton, Tampa
George Melvin Harms, New Orleans, La.
Henry Lytle Harrell, Jacksonville
Edward Alun Harris, Brewster
Milford Burriss Hatcher, Augusta, Ga.
David Yancey Hicks, Jr., Roberta, Ga.
John Patrick Higgins, Miami
Edgar Earl Hitchcock, Macon, Ga.
Milo Hayden Holden, Ft. Meade
Mary Stewart Howarth, DeLand
Roy Liddell Johnson, Atlanta, Ga.
Steve Renwick Johnston, Ft. Pierce
Lewis McCurdy Jones, Opelika, Ala.
Raymond James Kennedy, Joilet, Ill.
Theodore Charles Keramidas, Atlanta, Ga.
Marshall Kerry, Reading, Pa.

James Thomas King, Quitman, Ga.
Albert Charles Kirk, Sanford
Alexander Kushner, Venice
Alexander Graham Little, Jr., Valdosta, Ga.
Robert Bruce Logue, Montreal, Can.
Herbert Bradley Lott, Perry
Alexander Mackenzie Manson, Jacksonville
Dominic Anthony Marion, Miami
Jacob Louis Marks, Chicago, Ill.
Carl Sloan McLemore, Detroit, Mich.
James Somerville McLester, Birmingham, Ala.
Isaac Stephens McReynolds, Memphis, Tenn.
Wilbur Eugene Meneray, Lakeland
John Harold Mills, Lakeland
Pleasant Leonidas Moon, Atlanta, Ga.
Mitchell Lawrence Moran, St. Petersburg
Charles Russell Morgan, Jr., Miami
Max Knowles Moulder, Brooklyn, N. Y.
Irving I. Muskat, Chicago, Ill.
Juan Jose Navarro y Hernandez, Miami
Thomas Finn Nelson, Lakeland
Charles Willis Neville, Flat Creek, Ala.
James Robert Niederlehner, Miami
Harold George Nix, Opp, Ala.
James Benson O'Connor, Jacksonville
Alfred Eugene O'Neil, Cincinnati, O.
Elton Smith Osborne, Jr., Tampa
George Edwin Perkins, Atlanta, Ga.
Homer Allen Reese, Gallatin, Tenn.
William Carlton Rentz, Jr., Miami
John Alexander Renwick, Far Rockaway, L. I., N. Y.
William O. Rigby, Miami
Thomas Luther Roberts, Jr., Miami
Don Cook Robertson, Detroit, Mich.
Frank Young Robson, Tampa
Nathan Samuel Rubin, Pensacola
Joseph Ruskin, Tampa
Charles Scott Russell, Miami
Clarence Charles Saelhof, Chicago, Ill.
Thomas Asbury Sappington, Ft. Gaines, Ga.
Virgene Marie Scherer, Daytona Beach
John Martin Schultz, Chattahoochee
Zaven M. Seron, Sebring
Raymond Rinaldo Sessions, Winter Garden
John Edward Shay, Rochester, N. Y.
Irving Edmund Simmons, Jacksonville
Michael Smith, West Palm Beach
William Richard Snelling, Ft. McClellan, Ala.
William Daniel Snively, Jr., Cincinnati
Charles Frederic Stone, Jr., Atlanta, Ga.
Willis Jasper Taylor, Minden, La.
Richard Paul Thompson, St. Augustine
Rollin David Thompson, Orlando
Richard George Tietze, West Palm Beach
John King Garnett Tuten, McCormick, S. C.
Joseph Walter Weaver, St. Petersburg
William Hawley Weems, Boynton
Nathan Weil, Jr., Jacksonville
Harold Eugene Weller, Monongahela, Pa.
Sol Charles Werblow, Newport News, Va.
Franklin Bailey Wilkins, Mars Hill, N. C.
Paul Silas Woodall, Ft. Lauderdale
E. Bryant Woods, Ocala
John Dillard Workman, Savannah, Ga.

* * *

Drs. Juel Baker, Jack Cleveland, H. H. Cooke and Roy Holmes of Miami spent some time this summer vacationing in North Carolina.

* * *

Dr. Ralph E. Stevens of Chattahoochee attended the Florida Section of the Southeastern Surgical Congress at the Tampa Municipal Hospital, August 28, 1937.

Dr. J. I. Thorne of Miami just returned from special study of fever therapy in New York and Philadelphia and is now establishing a clinic for the fever treatment of gonorrhea and late syphilis.

* * *

Dr. and Mrs. O. W. Jenkins of Chattahoochee announce the birth of a son on August 27, 1937.

* * *

Dr. Thomas Kinsey of Miami, equipped with a trailer, spent his vacation on a tour of the far West. He spent some time in California and Washington.

* * *

Dr. C. L. Carter of Inverness announces the removal of his office from the Bank of Inverness Building to the second floor of the Masonic Building.

* * *

Dr. John Snyder of Miami spent his vacation in Boston and New York.

* * *

Dr. and Mrs. Thomas H. Lipscomb of Jacksonville announce the birth of a son, William Thomas, on Saturday, August 28.

* * *

Dr. Joseph Lucinian of Miami recently spent some time on Lookout Mountain. On his return, he was accompanied by his son who had been at Camp Cloudmont for six weeks.

* * *

Dr. J. A. Pines of Orlando left early in September for Chicago to spend his vacation. He planned to attend the Fifth International Congress of Radiology, September 13-17, and spend several weeks doing postgraduate work in roentgenology before his return.

* * *

Dr. Bascom Palmer and family of Miami are making an extended tour of Europe.

* * *

Dr. R. C. Woodard of Miami recently spent a brief vacation in Georgia.

* * *

Dr. Frank B. Voris of Miami Beach spent the summer in Wisconsin.

* * *

Dr. Edwin Preston of Miami Beach took postgraduate work in Baltimore and New York this summer.

Dr. Nathan S. Rubin, formerly of Pittsburgh, Pa., is now associated with Dr. M. A. Lischkoff of Pensacola. Following three years in the Eye Clinic at Montefiore Hospital in Pittsburgh, he served one year as Associate Resident Surgeon in Ophthalmology at Strong Memorial Hospital, Rochester, New York, and another year in a similar capacity at Mt. Sinai Hospital, New York City. In Pittsburgh he was a member of the Ophthalmological Staff of the Montefiore and Passavant Hospitals. He is a Fellow of the American Academy of Ophthalmology and Otolaryngology and Captain and flight surgeon in the Medical Reserve Corps of the U. S. Army. During the past year he has done postgraduate work in otolaryngology at Washington University, St. Louis, and at the Eye, Ear, Nose and Throat Hospital at Memphis.

* * *

Dr. W. D. Rogers of Chattahoochee recently spent two weeks in Tennessee and Georgia, visiting relatives.

* * *

Governor Fred Cone recently announced the reappointment of Dr. W. A. McPhaul as State Health Officer. The term of office is four years.

* * *

Dr. Sheldon A. Morris and Dr. Kenneth A. Morris of Jacksonville announce the removal of their offices to 238 West Church Street. The Doctors Morris have just completed a new office building on Church Street which is modernly equipped.

* * *

The Pacific Fleet will be in the port of Los Angeles during the Convention of the Association of Military Surgeons on October 14-16, 1937, at the Ambassador Hotel. An unusually interesting program has been prepared and the scientific and technical exhibits will be the largest in the history of the organization. Physicians, surgeons, dentists and veterinarians of the Army, Navy, Marine Corps, C. C. C. Camps and the Veterans Administration will be present. For additional information write to Robert L. Lewin, Ambassador Hotel, Los Angeles, California.

On Changing Brands of Cigarettes . . .

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Flinn, "Laryngoscope" Feb. 1935—Page 152

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★*Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245* ☐
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154 ☐
N. Y. Stdte Jour. Med., June 1935, Vol. 35, No. 11 ☐
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60 ☐

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Dr. and Mrs. Wiley M. Sams of Miami are receiving congratulations on the birth of a daughter, Bettie Jean, born August 15.

ALEXANDER S. HAWKINS

Dr. Alexander S. Hawkins of Clermont, age 87 died on July 22 of pneumonia, at the Lake County Medical Center, following an illness of five days.

Doctor Hawkins was born May, 1851, at Rossville, Georgia. He attended the University of Maryland, from which he graduated in 1879. His younger years of practice were spent in the West having served some thirty years as chief surgeon for the Frisco Railroad.

Doctor Hawkins came to Florida in 1923, locating at Clermont. He was a faithful member of the Lake County Medical Society, rarely missed a meeting, and always took part in the discussion of scientific programs. His intense interest was in organized medicine and its fight against quackery and state medicine. He believed in the personal administration of the physician, and it was to this noble mission he devoted his life. He was most active until the time of his demise, as shown by his delivery of two sets of twins a week prior to his terminal illness.

The following resolutions were adopted by the Lake County Medical Society, with reference to the passing of Doctor Hawkins:

"Whereas, God in His infinite wisdom hath seen fit to remove from our midst one of our most beloved brothers, Dr. A. S. Hawkins, and,

"Whereas, we, the members of the Lake County Medical Society, feel deeply the loss of our beloved brother and friend; therefore be it

"Resolved, that the Lake County Medical Society expresses its sorrow in the passing of Dr. Alexander S. Hawkins; that a copy of this resolution be sent to his family; that a copy be entered on the minutes of this society; and that the same be published in the Journal of the Florida Medical Association.

S. C. Colley, M.D.
R. H. Williams, M.D.
W. L. Ashton, M.D.
Committee."

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SUWANNEE RIVER MEDICAL MEETING

The Suwannee River Medical Society held its regular meeting at Madison, August 13, 1937. Dr. Edward Jelks, President of the State Association and Dr. W. McL. Shaw, Chairman of the Council, presented papers as guest speakers. This meeting was well planned and a most enjoyable occasion.

The first part of the program was held at 4 p. m. in the Madison Hotel where the scientific papers were read. This was made necessary in order to allow Doctor Shaw to have electric connections for operating his daylight projector. At the close of this part of the session the members and guests proceeded to a camp owned by Dr. Eustace Long on the banks of a stream some fifteen miles from Madison. Doctor Long extended all privileges of his camp to those present.

A fish fry was put on by the local committee on arrangements and the good food covering the improvised tables was a real treat. One of the special delicacies offered on the menu was "hush puppies." Those interested in fine southern cooking, who are not familiar with "hush puppies" should get in touch with the cook.

After all appetites had been satisfied with the bounteous repast the members and guests assembled in the large screened-in living room of Doctor Long's lodge. This room was equipped with heavy, comfortable chairs and settees. Oil lamps were lit and everyone settled down in the mellow glow in perfect comfort.

Dr. W. M. Ives, President of the Suwannee River Medical Society, presided and Dr. Harry S. Howell, the Secretary, recorded the proceedings. After some routine business of the society, the officers of the State Association were called upon for brief talks. President Edward Jelks was presented first; then Dr. Shaler Richardson, Secretary-Treasurer and Editor of the Journal; Dr. W. McL. Shaw, Chairman of the Council; and Stewart Thompson, Managing Director. The meeting then drifted into a general discussion concerning the activities of the Association and the problems of organized medicine.

Quite a number of doctors not now members of the Medical Association were in attendance and all seemed to enjoy the opportunities offered on this occasion. The attendance was especially good, with representation from practically the entire Suwannee River district.

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GYNECOLOGY — Two Weeks' Intensive Course starting September 20th and October 18th.

FRACTURES & TRAUMATIC SURGERY — Informal Practical Course; Ten Day Intensive Course starting October 11th.

OPHTHALMOLOGY — Two Weeks' Intensive Course starting September 20th.

OTOLARYNGOLOGY — Two Weeks' Intensive Course starting October 4th.

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Dr. Thomas S. Anderson of Live Oak, a life member of the State Association, was recognized and congratulated upon his ability to attend the meeting.

A resolution was adopted, upholding the action taken by the Executive Committee of the State Association recently in protesting the joint resolution introduced by Senator Lewis in the U. S. Senate.

CLINICAL CONFERENCE, SOUTHEASTERN SURGICAL CONGRESS

The third annual clinical conference of the Florida section of the Southeastern Surgical Congress was held at Tampa on Saturday, August 28. This meeting was open to all members of the State Association and a large audience was present. The following men appeared on the program: Drs. D. C. Donald, Birmingham, Ala., J. U. Reeves, Mobile, Ala., Frank Boland, Atlanta, Ga., Alfred A. Walker, Birmingham, G. R. Douglas, Birmingham, T. Z. Cason, Jacksonville, M. S. Equen, Atlanta, O. O. Feaster, St. Petersburg, Thomas P. Goodwyn, Atlanta. Dr. B. T. Beasley of Atlanta, Secretary of the Congress, was present and made a talk at the lunch period.

The meeting was held at the Municipal Hospital and a most enjoyable lunch was served by the Hospital to those in attendance.

Dr. J. S. Turberville of Century, Dr. Leland F. Carlton of Tampa, and Dr. Frank T. Gray of Orlando composed the committee in charge of arrangements for the Southeastern Surgical Congress.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Dade County Medical Society was held Friday, August 6, at 8:30 p. m., in the assembly room of the Florida Power and Light Company. Doctor Burch, president, presided. The minutes of the last meeting were read and approved.

There was no scientific program as the purpose of this meeting was to hear a report from the Economics Committee and to discuss group hospitalization and hospital insurance.

DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The regular monthly meeting of the DeSoto-Hardee-Highlands County Medical Society was held in Wauchula, Tuesday evening,



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August 10, with the following members present: Doctors McSwain, Kayton, Kirkpatrick, Spears, McKnight, Poucher and Martin. Visitors present were: Dr. Philpot of Bowling Green, Lieut. Col. Lee Harding of Camp Patterson in Ohio and Dr. W. B. Clements of Minnesota. Dr. G. C. Freeman of Lakeland did not appear as the essayist of the evening, but a round table discussion of many diseases and treatments proved to be of interest to all. Among the subjects considered were tetanus, meningitis, snake bite, electric shock, and sulphanilamide.

There was no business and the meeting adjourned. The Society meets in Wauchula in September.

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society held its regular meeting at the Shrine Club on September 3 at 6 p. m. The principal speaker of the evening was Dr. C. S. Franckle of St. Petersburg, who presented a paper on "Alcoholic Injection for Relief of Pain."

At the meeting of the Pinellas County Medical Society held at the Shrine Club on August 20, Dr. W. C. McConnell was principal speaker. He presented a paper on "Endocrinology in Psychiatry."

BOOKS RECEIVED

Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.

SYPHILIS, THE NEXT GREAT PLAGUE TO GO. By MORRIS FISHBEIN, M. D., Editor, The Journal of the American Medical Association. A book on Syphilis for the lay reader, which gives in clear, concise, non-technical language the information which the average reader wants. Illustrated. Cloth. Price $1.00. Pp. 70. David McKay Co., Philadelphia.

YOUR DIET AND YOUR HEALTH. By Morris Fishbein, M. D., editor, Journal of American Medical Association. The author examines the claims of several of the most widely-publicized of the diets offered the public, weighs their merits, and in some instances criticizes them severely, showing that they are grossly unscientific. But he does not stop there. He sets forth in simple terms the most up-to-date and generally recognized truths of what is now known about diet, with full discussions of the proportions of protein, carbohydrate and fat recommended; the value and use of minerals; the real importance of vitamins. There are also special sections on suggested diets; food "sensitivities"; and, in general, much common sense on a subject which has been peculiarly obscured by fads. Cloth. Price $2.50. pp. 298. McGraw-Hill Book Co., New York.

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COMPONENT SOCIETIES BY DISTRICTS—FLORIDA MEDICAL ASSOCIATION

Districts	County Society	President	Secretary	Meeting Date	Councilor and Counties Not Included in First Column	Members	
						Total	Paid
Northwest District (A) Apalachicola, July 15, 1937	Bay	D. M. Adams, M. D., Panama City	Allen H. Miller, M. D., Millville		A-1-'38 John S. Turberville, M. D., Century	12	10
	Escambia	J. C. McSween, M. D., Pensacola	J. M. Hoffman, M. D., 1221 E. DeSoto St., Pensacola	2nd Tuesday 8:00 P. M.		38	35
	Walton-Okaloosa	A. G. Williams, M. D., Lakewood	R. B. Spires, M. D., DeFuniak Springs	3rd Thursday 8:00 P. M.		5	100%
	Washington-Holmes	G. W. Carter, M. D., Caryville	F. M. Watson, M. D., Chipley		*Santa Rosa*	7	6
	Jackson	C. H. Ryals, M. D., R.F.D. No. 1, Grand Ridge	Lewis Pierce, M. D., Marianna	2nd Tuesday 7:30 P. M.	A-2-'39 N. A. Baltzell, M. D., Marianna	15	12
	Leon-Gadsden-Liberty-Wakulla-Jefferson	L. L. Dozier, M. D., Tallahassee	B. A. Wilkinson, M. D., Telephone Bldg., Tallahassee	Quarterly 3:00 P. M.	*Calhoun-Franklin-Gulf*	37	35
North Central District (B) Ocala, October 7, 1937	Columbia	T. H. Bates, M. D., Blanche Hotel Annex, Lake City	M. W. Spearman, M. D., Morrison Bldg., Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M. D., Lake City	13	100%
	Madison	E. Long, M. D., Madison	Geo. O. Davis, M. D., Madison			4	100%
	Taylor	G. H. Warren, M. D., Perry	J. C. Ellis, M. D., Perry	Last Friday 8:00 P. M.	*Baker-Dixie-Hamilton-Lafayette-Suwannee*	8	100%
	Alachua	T. A. Snow, M. D., 103 E. University Ave., Gainesville	H. M. Merchant, M. D., 124 E. University Ave., Gainesville	2nd Friday 7:30 P. M.	B-4-'38 A. B. Albritton, M. D., Wildwood	26	20
	Marion	Ralph E. Russell, M. D., Ocala	R. C. Cumming, M. D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P. M.		22	100%
	Pasco-Hernando-Citrus	W. Wardlaw Jones, M. D., Dade City	G. R. Creekmore, M. D., Brooksville	2nd Thursday 7:00 P. M.		13	100%
	Sumter	A. B. Albritton, M. D., Wildwood	W. E. Mitchell, M. D., Bushnell	2nd Tuesday	*Bradford-Gilchrist-Levy-Union*	4	100%
N. E. District (C) St. Augustine, Sept. 23, 1937	Duval	Kenneth A. Morris, M. D., 238 W. Church St. Jacksonville	George W. Croft, M. D., 713 Greenleaf Bldg., Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M. D., Jacksonville	157	128
	St. Johns	Charles C. Grace, M. D., East Coast Hospital, St. Augustine	R. D. Harris, M. D., St. Augustine	3rd Tuesday 8:30 P. M.	*Clay-Nassau*	11	100%
	Putnam	H. A. Johnson, M. D., Palatka	F. Emory Bell, M. D., Palatka	2nd Thursday 7:00 P. M.	C-6-'38 Hugh West, M. D., DeLand	9	100%
	Volusia	J. Ralston Wells, M. D., Woolworth Bldg., Daytona Beach	R. L. Miller, M. D., 258½ S. Beach St., Daytona Beach	2nd Tuesday 7:30 P. M.	*Flagler*	40	38
Southwest District (D) Plant City, November 11, 1937	Hillsborough	George L. Cook, M. D., 442 W. Lafayette Tampa	James S. Grable, M. D., 811 Citizens Bank Bldg., Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M. D., Plant City	100	95
	Manatee	Lowrie W. Blake, M. D., Bradenton	M. M. Harrison, M. D., Bradenton	3rd Tuesday 7:00 P. M.		12	100%
	Pinellas	N. M. Marr, M. D., 812 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D., 1005 Equitable Bldg., St. Petersburg	1st and 3rd Fridays 6:30 P. M.		87	86
	Sarasota	O. H. Cribbins, M. D., 224 Commercial Court, Sarasota	J. E. Harris, M. D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P. M.		18	14
	DeSoto-Hardee-Highlands	Gordon H. McSwain, M. D., Arcadia	L. W. Martin, M. D., Sebring	2nd Tuesday 8:00 P. M.	D-8-'38 J. A. Simmons, M. D., Arcadia	19	100%
	Lee	H. Quillian Jones, M. D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M. D., 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P. M.		13	100%
	Polk	R. E. Gilbert, M. D., 19 Postal Arcade, Winter Haven	J. R. Boulware, Jr., M. D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	*Charlotte-Collier-Glades-Hendry*	61	57
South Central District (E) Melbourne, Oct. 21, 1937	Brevard	W. C. Page, M. D., Cocoa	Bob Schlernitzauer, M. D., Rockledge	3rd Tuesday	E-9-'38 W. C. Page, M. D., Cocoa	10	5
	Lake	LeRoy H. Oetjen, M. D., Leesburg	W. L. Ashton, M. D., Umatilla	1st Thursday 12:30 P. M.		17	16
	Orange	F. H. Harms, M. D. 64 No. Court St., Orlando	Hewitt Johnston, M. D., Box 2002 Orlando	3rd Wednesday 8:30 P. M.		58	56
	Seminole	H. D. Smith, M. D., Touchton Drug Bldg., Sanford	Douglas G. Scott, M. D., Box 489 Sanford	2nd Monday 7:00 P. M.	*Osceola*	13	100%
	St. Lucie-Okeechobee-Indian River-Martin	H. D. Clark, M. D., Bank & Trust Bldg. Ft. Pierce	Grover C. Hardie, M. D., 207½ Orange Ave. Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M. D., Ft. Pierce	14	100%
S. E. District (F) Miami, Sept. 8, 1937	Broward	George S. McClellan, M. D., Pompano	Oliver C. Brown, M. D., 915 Sweet Bldg., Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'38 F. K. Herpel, M. D., West Palm Beach	29	100%
	Palm Beach	Bailey B. Sory, Jr., M. D., Brazilian Court Hotel, Palm Beach	Lloyd J. Netto, M. D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P. M.		55	51
	Dade	R. N. Burch, M. D., 1774 S. W. Eighth St., Miami	Walter C. Jones, Jr., M. D., 802 Huntington Bldg., Miami	1st Friday 8:30 P. M.	F-12-'39 H. A. Walker, M. D., Miami Beach	261	240
	Monroe	Harry C. Galey, M. D., 532 Fleming St., Key West	W. R. Warren, M. D., 511 Eaton St., Key West	1st Sunday 9:00 P. M.		3	100%



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American Medical Association, San Francisco, June 13-17, 1938.
Southern Medical Association, New Orleans, November 30—December 3, 1937.

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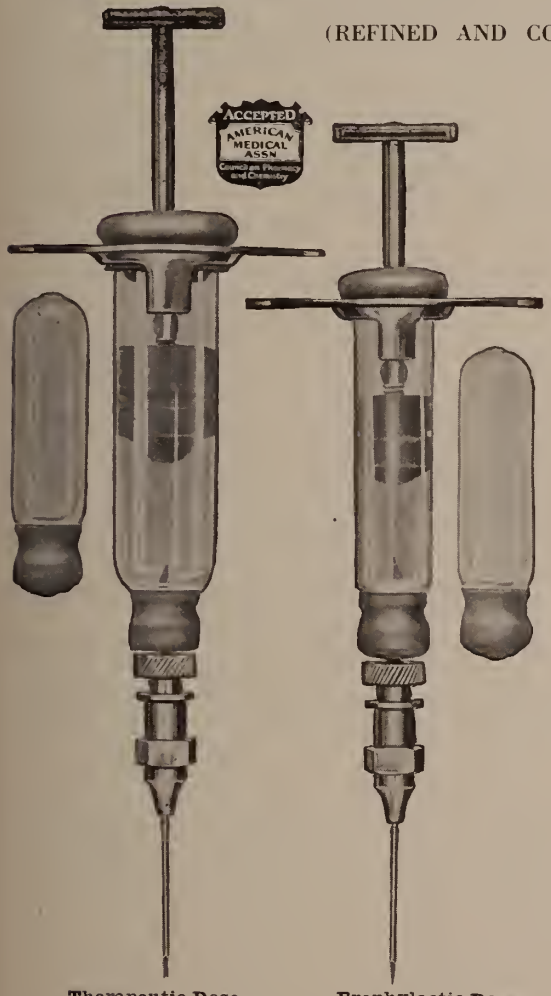
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CANNED FOODS IN THE CONTROL OF LATENT AVITAMINOSES

● In June, 1935, this space was devoted to a discussion of some of the general aspects of latent avitaminoses. It appears pertinent to report some of the more recent ideas in regard to this important field.

Considering the subject of avitaminoses in its entirety, the modern medical attitude is aptly expressed by the following statement: "... the mild or latent forms of the vitamin deficiencies are more important in practice at present than the fully developed cases. The latter are uncommon, are easily recognized and are usually promptly and adequately treated. On the other hand there is reason to believe that minimal or mild forms of these diseases are much more frequent, often escape recognition and, because of their insidious effect on large numbers of people, constitute a more serious problem than the occasional advanced cases." (1)

Consideration of this statement brings home the importance of optimum vitamin intake. Students of nutrition agree that in order to achieve this objective, a liberal and varied diet must be available. The constituents of the diet should be wholesome foods, the preparation of which has not materially reduced their intrinsic nutritive values. Commercially canned foods fall well within this classification.

Modern canning procedures are designed to protect the vitamin potencies of the food. Recent reports in the scientific literature indicate the success attained in retaining vitamin values in commercially canned foods. (2)

In general, the control of latent avitaminoses and the advancement of positive health appear to be largely matters of practical application of facts made available by the modern science of nutrition. We wish to direct attention to the part which the wide variety of canned foods available on the American market may play in establishing dietary regimes calculated to control the avitaminoses.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) 1937. J. Am. Med. Assn. 108, 15.
(2) 1936. J. Nutr. 12, 405.

(2) 1936. J. Am. Diet. Assn. 12, 231.
1936. J. Nutri. 11, 383.
1936. Ind. Eng. Chem. 28, 1009.

(2) 1935. J. Home Econ. 27, 658.
1935. U. S. Pub. Health Rpts. 50, 1333.
1935. Am. J. Pub. Health 25, 1340.

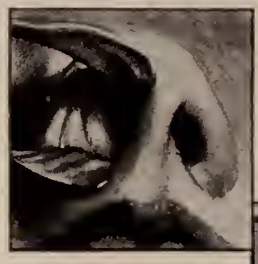
This is the twenty-ninth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

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Acute Rhinitis in Children





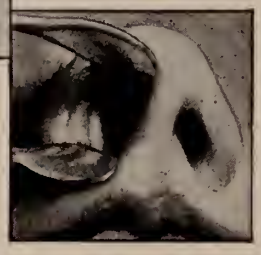


FIG. 1. J. M. C. White, female, age 4. June 5, 1936. Acute rhinitis. 11:40 A.M. Two inhalations of 'Benzedrine Inhaler'.

FIG. 2. 11:50 A. M. Maximum shrinkage evident.

In 100 cases of acute rhinitis in children from two months to twelve years of age treated with 'Benzedrine Inhaler' Scarano and Coppolino report prompt and adequate shrinkage of the nasal mucosa in 97 per cent. — Arch. Pediat. **54**: 97, 1937.

The vapor form — in addition to its greater effectiveness — overcomes the strenuous objections which children show to liquid inhalants as applied by drops, tampons or sprays. Obviously, however, as with any medication for children, an adult should supervise the use of the Inhaler and retain possession of the tube.

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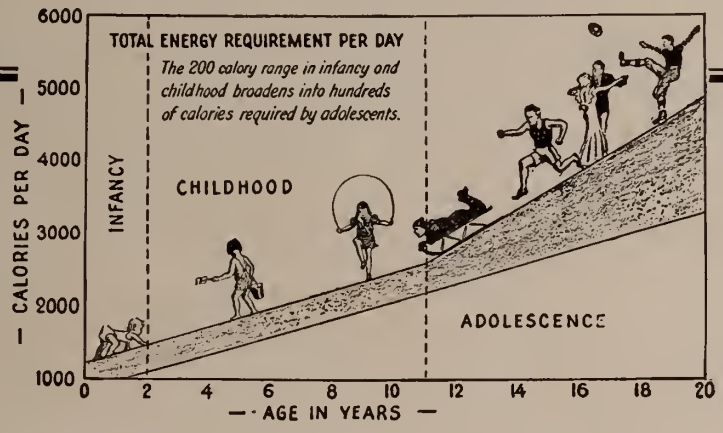
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Some of these symptoms are physiological manifestations of adolescent development.

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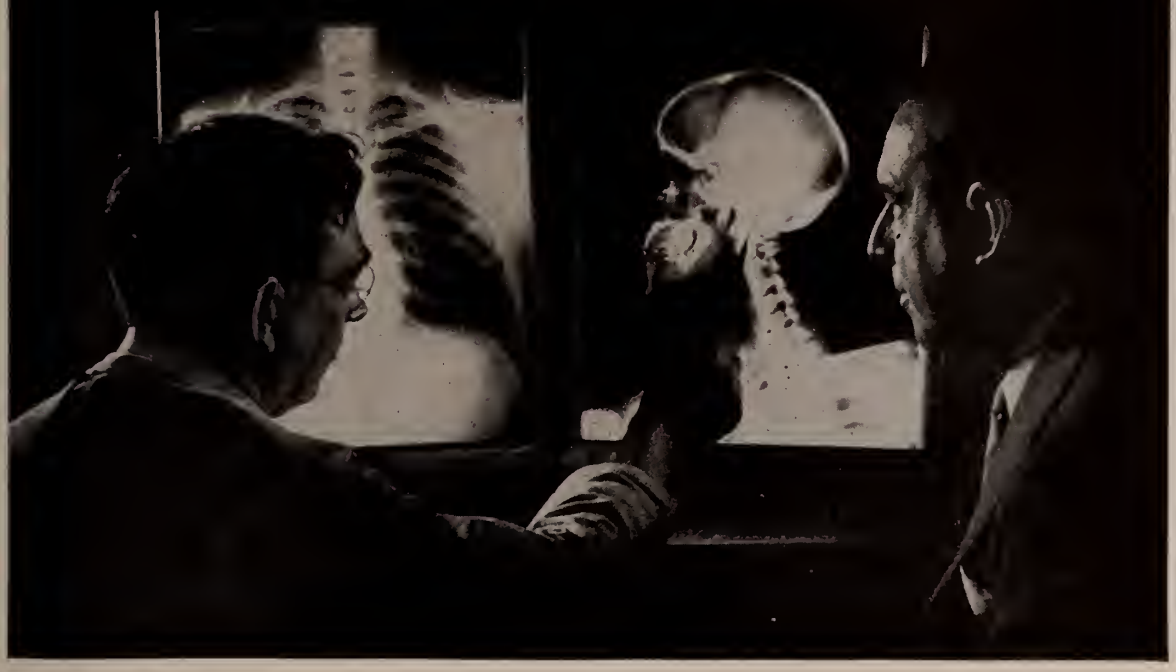
Insulin Squibb of the usual strengths is supplied in 5-cc. and 10-cc. vials.

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APPENDICITIS IN CHILDREN*

Douglas D. Martin, M. D.
Tampa

The seriousness of acute appendicitis in children stimulates all physicians to a more determined effort to lower the mortality rate. The reported increase in appendicitis in children is due, no doubt, to a greater accuracy in diagnosis. The mortality rate in children is greater than in older patients. The possibility of appendicitis should not be excluded because of the absence of the typical symptom sequence because any of the following can happen: evacuation of the irritating appendiceal contents into the cecum; patency of the lumen through the entire attack; interference with the neuromuscular mechanism of the viscus; and ptosis of the appendix into the pelvis.

A few things that will cause abdominal pain in children, but should not seriously interfere with your differential diagnosis in appendicitis, are:

Pott's disease, pelvic disease, lead poisoning, urinary tract infection, disease of gall bladder and bile duct, epigastric hernia, intestinal worms, abdominal adenitis, tuberculous peritonitis, erythematous group of skin lesions, gastro-intestinal allergy, malformation of the intestines, redundant colon, spasm of the intestines, injuries to the abdomen, constipation and indigestion, physic causes, intussusception.

Appendicitis cannot be diagnosed in children unless one is constantly thinking of the appendix and its many peculiarities. It is probably well to suspect the appendix in all acute abdominal pain, past the second year of life. Before the second year it is wise to think of an intussusception, where the child is suffering with severe abdominal pain. Abdominal pain can occur at any age and when it does occur, differentiation from other conditions is at times extremely difficult. The removal of an innocent appendix is justifiable when there is a reasonable doubt and you are bold enough to take this precaution.

A child with appendicitis will not willingly allow you to examine his abdomen—he will push your hand away. This sign is nearly always present after inflammatory process has existed any length of time. Children seem to draw the right leg up more than adults. The pain is always increased when the child is asked to assume the sitting position and in walking he will incline his body to the right. I have noted that the pain in early appendicitis is most often around the umbilicus and, on pressure, the tenderness is in the lower quadrant. It is advisable always to do a digital examination because so frequently the point of tenderness is low in the abdomen and it can best be detected in this manner.

Pelvic appendicitis where severe pain is a constant symptom also deserves attention. This condition often causes severe pain around the umbilicus but quickly settles in the lower abdomen. The children are awakened at night with severe abdominal pain—most often in the left side. One of the outstanding symptoms is irritation on micturition which condition may be the only constant symptom. The appendix being low under the bladder, a constant desire for defecation may result. This, with the desire for micturition, forms an important symptom. Blood in the urine is usually found in these cases. In girls the pelvic organs have to be carefully considered in differential diagnosis. Stones in the ureter must not be overlooked.

Bear in mind the rotation of the cecum in infants with abdominal pain; this location of the cecum might confuse the location of the tenderness. The appendix, normally, is located in the right iliac fossa—subjacent to McBurney's point, which marks the junction of the two lower thirds of a line connecting the right anterior superior iliac spine with the umbilicus. This position is attained as the result of intra-uterine changes in the intestinal canal, involving a gradual migration of the iliocolic junction from a primary position in the left iliac fossa, upward to the right, be-

*Read before the Sixty-fourth annual meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, 1937.

neath the liver and finally downward into the right iliac fossa.

When these changes are not completed, the appendix will not be found in its normal adult location, but frequently higher in the abdomen. Because of the variation in development, the appendix may or may not have its origin from the extreme lower portion of the cecum. The lumen of the appendix at its base is often very minute. The total diameter of the appendix is about one-fourth of an inch; the length, which is extremely variable, is usually between two and three inches.

Nausea and vomiting are secondary in considering appendicitis. Do not expect to find abdominal distention in early appendicitis—you will find more flat abdomens than you will distended ones.

Differentiating pneumonia and appendicitis should not be a major problem. Pneumonia gives an early high temperature. In appendicitis, the early temperature is low. In pneumonia, the white cells range from 15,000 to 25,000 with granulocytosis. In appendicitis, the blood picture is different. The white cell count of 6,000 - 13,000 with polymorphonuclear increase, make you think of appendicitis. One word of warning about the blood picture: I have seen a ruptured, gangrenous appendix with a low cell count; again, I have seen an acute catarrhal appendix with a relatively high cell count. The blood count is only one of the many aids you can use in making your diagnosis. It is certainly not to be too greatly stressed. Those of us who treat children see many with acute abdominal pain and it is rare to see one who has not been given an initial purge with an enema. I am at a loss to tell you whether a dose of milk of magnesia with an enema does much damage to the appendix. However, I am not going on record as favoring the purgation of any case of appendicitis nor do I make a practice of ordering laxatives, but I am mentioning this because we do see these children who have been so treated and apparently all of them are not harmed. Personally, I believe, after the diagnosis is once made, the child would be much better if we would refrain from continuous palpating and seeing how hard we can poke his abdomen, two, three or four times a day, by as many different examiners. In acute obstructive appendicitis the pain is more severe—colicky in nature and more often in the midline, relatively high in the abdomen; the temperature is low; as a rule, there is no rightsided tenderness; not much, if any, rigidity; in fact, very few physical findings. This is the type that is so often fatal. Acute inflammatory appendicitis localizes very quickly in the lower right quadrant with all the cardinal symptoms: rigidity, tenderness, temperatures and blood findings.

A mechanical lesion of the appendix includes a history of recurrent short attacks of abdominal pain which may be dull, burning or stabbing and have no relation to food intake. Exercise usually increases the pain which is, at first, localized in the umbilical or epigastric region, later to appear in the right, lower quadrant. The passing of stools, flatus or vomiting may relieve the attack.

The diarrhea or constipation cannot be used as a guide in helping you in your diagnosis. A late diarrhea indicates a pelvic inflammatory process—most likely a pelvic abscess. In rightsided pain, you must not overlook a pyelitis. Bear this in mind, especially in girls—the temperature is higher in pyelitis and they are prone to have chills. I have found in severe cases of pyelitis, before getting urinary findings, that the pain and tenderness was over the region of the kidney. The extremities are nearly always cold in kidney infections; the skin will feel cool and the temperature will be 105. Examine every specimen of urine that is obtainable in children and your efforts will be rewarded. I cannot stress too much, frequent urine examination. Sometimes pus and clumping will appear in one specimen and then for twenty-four hours there will be no other findings.

Appendicitis is rather more frequent in children who have suffered from digestive disturbances, particularly chronic constipation. The bacteria most frequently found in abscesses from appendicitis are streptococci, usually associated with colon baccilli. Inflammation of the appendix may be acute catarrhal, suppurative or gangrenous and it may be recurrent or chronic.

When should this child undergo operation? This question is always foremost in our minds. We might say: "when the diagnosis has been made," and in large percentage of the cases we would certainly be following a conserva-

tive routine. If the patient is not seen early or if a positive diagnosis has not been possible until considerable local inflammation has developed, the decision as to operation should depend upon the course of the symptoms in the individual case. If the disease is progressing favorably, the inflammatory area not increasing and the constitutional symptoms steadily subsiding, it might be advisable to wait for the abscess to form. If abscess formation does not occur, then one may wait until resolution occurs before operating. There is always the chance of grave dangers occurring in those cases that are apparently progressing nicely and sometimes, in waiting, the most favorable time has been lost. All cases of appendicitis should be watched closely and the surgeon should be ready to operate at the slightest unfavorable symptom. Only a small proportion of cases in children can be expected to terminate in resolution. The omentum in children is less developed than in adults and the chances of walling off the infection is lessened.

Relative to the preoperative and postoperative care of these cases, it is most important that some thought be given the type of treatment best suited for the case, whether it is an emergency operation or an elective operation.

In the emergency case, time often forbids the necessary thorough study of the individual case, but we must consider the nervous, irritable child. Some suitable sedative should be used, either by mouth or rectum. When the child goes to the operating room well relaxed, he will need less general anesthesia and consequently will react more favorably after the operation. If a child is dehydrated and a poor surgical risk, glucose, saline and calcium should be given before and after the operation.

In the elective type of operation, a thorough study of the blood, urine and stools is always necessary. A gastro-intestinal x-ray series is helpful in certain types of cases.

The postoperative care of children is as a rule a simple procedure: small quantities of warm water and fruit juices for twenty-four to forty-eight hours, followed by an increase of fluids. As a rule, they will be ready for a modified soft diet and an enema about the fourth day—then on to a regular modified general diet.

Conclusion

To diagnose appendicitis, one must bear in mind the many peculiarities of the disease, and always advise operation if confronted with an appendix suspected of being diseased.

Remember that appendicitis can and does occur in any age, both infancy and childhood. In the past few years the increase is no doubt due to our knowledge of the individual case and on more frequent physical examinations.

DISCUSSION

Dr. Warren W. Quillian, Coral Gables:

The tragedies associated with undiagnosed appendicitis have made both the medical man and the layman more acutely conscious of this pathologic condition. Unfortunately, there is no typical clinical picture of appendicitis. Dr. Martin calls our attention to the real menace of an attitude of complacency toward abdominal pain in children. During the years 1900-1930 in Massachusetts the child population increased 41 per cent. Yet during this same period child deaths from appendicitis increased 428 per cent. From 1926 to 1930 the disease ranked eighth, and from 1926 to 1933 it ranked fifth, among causes of death in the age group one to nine years.[1]

It is well to remember that appendicitis may co-exist with or be associated with other infectious diseases. Observers have noted that the incidence rises in association with measles or upper respiratory infections.[1]

The classical triad of symptoms (pain in the abdomen, vomiting and fever) seldom is found among children. Probably the most common subjective symptom is abdominal pain. Dr. Martin stresses the importance of the unrotated cecum and other congenital abnormalities which tend to vary the picture. His remarks are based upon a rich clinical experience and the conclusions drawn are those of a shrewd observer. We are indebted to him for discussion of a very timely subject. In no other condition is there more need for keen diagnostic acumen, mature judgment and the courage of one's convictions. It is extremely helpful for the pediatrician or the general practitioner to have available the counsel and services of a good surgeon. Together they can usually plan procedure along a course that is advantageous to the best interests of the little patient. Each case constitutes an in-

dividual problem, and demands the intelligent interest of the physician from the moment the diseased condition is first suspected.

REFERENCE

1. Hudson, Henry W., Jr., and Krakower, Cecil: Acute Appendicitis and Measles, N. E. Jour. Med. 215: 59 (July 9) 1936.

Dr. Wm. W. McKibben, Miami:

I was requested to discuss a paper on "pyelitis" by Dr. Martin at the meeting of the Southern Medical Association in Miami in 1930. We were impressed with his masterful presentation then; so, too, I am this morning. I wish but to emphasize a few salient facts of this important paper.

In appendicitis in children there is, first, the group that is not going to rupture; second, those that will rupture but remain localized; third, those that will rupture and spread. In the first two groups the mortality is the same as in adults; but in the third the mortality is twice as great, 34 compared to 16 per cent in adults. I wonder if this is due to the longer omentum giving greater protection in adults.

Apprehensive parents, appendicitis minded, call the pediatrician to see many infants and children with acute abdominal pain. Very few turn out to be surgical emergencies. But there is always the potentiality of a dramatic case becoming a tragic one. It is a wise doctor who early calls in a competent surgeon to share his responsibility. Quickly get together a complete history, physical examination, and laboratory work (white counts, differentials, and urine analyses), so that the surgical consultant has every advantage in weighing the evidence in a cool, logical way.

The catarrhal inflammation of ileocolitis is common; the acute suppurative type of appendicitis in babies and children is, comparatively, much rarer. Given an abdomen under suspicion with anorexia, bradycardia, then tachycardia or irregular pulse, slight fever, nausea or vomiting, diarrhea or constipation, the baby lies quietly and scarcely moves. We examine the enlarged abdomen carefully and slowly. When we palpate the surgical belly around the appendix; the young child pushes the hand away, always trying to protect himself by muscular defense. We establish definite localized rebound tenderness, and the presence of this muscle-guard; then quickly we get together the laboratory facts, and call the surgeon; together we examine by rectum for tenderness or mass. Conservative watchful waiting may be proper in some diseases of children, but not so in doubtful cases of acute appendicitis. However, the burden of exclusion of the diseases emphasized in Dr. Martin's able differential diagnosis rests with us.

One of my severest recent cases was a boy of 13 months, seen with the family doctor at midnight. The boy had a history of recent tonsillitis and was guilty of an indiscretion in diet (popcorn and peanuts). Examination revealed broncho-pneumonia and a suspicious appendix. At daybreak a competent surgeon and roentgenologist advised operation under local anesthesia. This was successful, although the appendix had ruptured. Later, x-ray showed that the pneumonic process had almost cleared up three days after the operation.

In the course of long years of practice, a physician has a number of these dramatic and interesting cases to recall.

At 6 p. m. on a raw November, New England day, a capable trained nurse telephoned that a boy of two was extremely ill with what appeared to be acute pneumonia; temperature 104, grunting expirations of 80. He had had a cold for a week. His anxious face, mouth-pallor, flushed cheeks, cough, cold and toxic appearance certainly suggested pneumonia. But not even diminished breath-sounds or fine pleuritic rales were found in his chest or back. At the laboratory the urine proved negative, but the blood showed a 4 per cent eosinophilia. At 8 p. m. I obtained the history I should have gotten on my first visit. The boy had eaten manure from around a rose bush the preceding July. Ten days before (in early November) he had vomited a dead ascaris lumbricoides. Now, his abdomen was distended, tense, tympanitic and tender all over. His fever was due to the toxemia; his rapid, grunting expirations to pressure, pain and toxemia. I gave him calomel and santonin, followed by magnesia. At 2 a. m. he passed 68 stomach-worms, varying in length up to eleven inch females. In 30 days he passed a total of 378 round-worms. He felt better!

Dr. Douglas D. Martin, (Concluding):

I want to thank you for your discussion of this subject.

Remember that we do have appendicitis in children and we have it too frequently and the mortality rate is higher than it should be.

The location of the pain in appendicitis is confusing and is not always over McBurney's point. Appendicitis, apparently, does not go to resolution as quickly as it does in adults.

Castor oil and calomel certainly have no place in the treatment of appendicitis where there is ever any abdominal pain. Drastic purgation should always be avoided.

The youngest child that I have seen with appendicitis, was six months of age and the appendix was ruptured in this case.

VENEREAL DISEASES*

CAN WE HOPE TO CONTROL AND POSSIBLY ERADICATE SYPHILIS AND GONORRHEA?

Henry E. Palmer, M. D., Tallahassee

I shall not attempt to present anything new in the etiology or treatment of these diseases. My purpose is to call to your attention the nation-wide campaign that is being waged against them, to arouse your interest, and get your active cooperation in this important campaign. Surgeon General Thomas Parran, U. S. P. H. S., is deeply interested in controlling venereal diseases. He is a wise, determined, and experienced leader, and will exercise his influential power to aid us in this worthy undertaking.

Syphilis

I will first speak of syphilis because of its universal prevalence, and destructive results in its victims. Its origin and source is still not known. The sudden and rapid spread over Europe and the world followed the return of Columbus, and his sailors from the discovery of the new world. It was definitely recognized from his first trip to the West Indies in 1493. It is interesting to note that the disease got its name from a poem written by an Italian poet, Fracastor, in 1521. The poem deals with a shepherd named Syphilis who blasphemed because his sheep suffered greatly from drought. As a punishment the sun god covered him with sores and afflicted him with other bodily ailments so that he suffered sleepless nights. Hence the name Syphilis.

*Read before the Sixty-fourth Annual Meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, 1937.

There is no doubt that syphilis is our greatest hazard to life and health. Sir William Osler once said that it was the first of our killing diseases. It is not overstating facts to say that fully 100,000 American deaths annually occur from its ravages. A million new cases occur annually, and over 6,000,000 of our people are infected with it. It is the cause of numberless abortions, and stillbirths, and partly responsible for the many babies that are born too weak and diseased to live. It is the cause of fifteen per cent of blindness and of all the locomotor ataxias and paresis that we see on our streets and in the hospitals for the insane. It is frequently the cause of apoplexy, paralysis, heart and blood diseases. It is the most insidious and destructive of all diseases to health, happiness and life; the most ravaging, attacking all tissues of the body; and in the long run, the most expensive to society and the state.

A letter and report from the Bureau of Vital Statistics from the efficient, able and courteous statistician, Stewart G. Thompson, D. P. H., covering the years 1917 to 1935 is attached hereto. It is complete, enlightening, and interesting. I wish to express my thanks to Doctors Stevens and Thompson for their assistance:

State Board of Health
Bureau of Vital Statistics
Jacksonville, Florida

SYPHILIS DEATHS AND DEATH RATES PER 100,000 POPULATION BY COLOR, FLORIDA, 1917-1935

Years	TOTAL			WHITE			COLORED		
	Pop.	Deaths	Rate	Pop.	Deaths	Rate	Pop.	Deaths	Rate
1935	1,614,000	425	26.3	1,145,000	108	9.4	469,000	317	67.6
1934	1,585,596	485	30.6	1,124,007	94	8.4	461,589	391	84.7
1933	1,557,976	450	28.9	1,103,156	90	8.2	454,820	360	79.2
1932	1,530,356	382	25.0	1,082,305	90	8.3	448,051	292	65.2
1931	1,502,736	458	30.5	1,061,454	108	10.2	441,282	350	79.3
1930	1,475,116	424	28.7	1,040,603	101	9.7	434,513	323	74.3
1929	1,431,645	374	26.1	1,006,324	76	7.6	425,321	298	70.1
1928	1,382,889	438	31.7	967,569	89	9.2	415,320	349	84.0
1927	1,334,134	367	27.5	928,814	93	10.0	405,320	274	67.6
1926	1,285,380	334	26.0	890,059	77	8.7	395,321	257	65.0
1925	1,236,625	235	19.0	851,304	72	8.5	385,321	163	42.3
1924	1,187,870	190	16.0	812,549	37	4.6	375,321	153	40.8
1923	1,139,114	179	15.7	773,794	37	4.8	365,320	142	38.9
1922	1,090,359	140	12.8	735,039	27	3.7	355,320	113	31.8
1921	1,041,604	129	12.4	696,285	24	3.4	345,319	105	30.4
1920	992,848	119	12.0	657,530	21	3.2	335,318	98	29.2
1919	957,353	108	11.3	628,135	17	2.7	329,218	91	27.6
1918	935,119	132	14.1	608,098	30	4.9	327,021	102	31.2
1917	912,886	206	22.6	588,062	39	6.6	324,824	167	51.4

A letter from Dr. Ralph E. Stevens, Chief Physician of our State Insane Asylum gives us the following interesting statistics:

"We made a recent check of our inmates and found that we had 761 syphilitics. Of these 132 were white males, 58 were white females, 293 were colored males and 275 were colored females. This is approximately 17% of the inmates of the institution.

"Syphilis was directly responsible for the mental condition of 69 white males, 29 white females, 139 colored males, and 133 colored females. There may be some recent admissions in whom a diagnosis has not been made but this would not materially change the percentage. It costs approximately $400.00 per year to maintain each patient."

Syphilis has been successfully checked, controlled, and the number of cases materially reduced in Scandinavia and England by governmental aid, follow-up method, and stringent health laws.

New York State, and Scandinavia, (embracing Norway, Sweden, and Denmark) have approximately equal populations. Scandinavia under careful and vigorous governmental care and treatment, report 1,600 new cases annually, while New York State has about 45,000 cases yearly. In Scandinavia the outstanding principle in the program of syphilis control is that all persons infected with syphilis have a right to demand free treatment, *but* equally are obliged to submit to treatment. In putting this principle to work four *MUSTS* are clearly prescribed by law and regulation.

All cases *must* be reported; all who are infected *must* take treatment; treatment *must* be available to all infected; if desirable for the protection of contacts, patients *must* be hospitalized.

Dr. Thomas Parran, Surgeon General, U. S. P. H. S., suggests the following program:

1. Find syphilis—The obscure cases will never be found in time except by the Wassermann dragnet.

2. Treat syphilis promptly—a few days' delay may mean failure of treatment.

3. Examine for syphilis the family and all other contacts of the syphilis patient.

4. Prevent the birth of syphilitic babies by requiring blood tests before marriage and early in each pregnancy.

5. Teach syphilis. The facts about it must be known to all people. Bar the quack doctor, the advertising charlatan, and drug store prescriber. To put this over successfully requires the cooperation of physicians, patients, and the public. This activity requires a big outlay of money. Where is the latter coming from? Again I quote Doctor Parran as follows:

"Certainly we need money to fight syphilis, but no more money than the communities can be educated to use wisely. Our $8,000,000 grant in aid to the states, as provided by the Social Security Act, is enough for this coming year. The Public Health Service will not dictate to the states the purposes for which this money is to be used, but certainly they could put it to no better use than the control of syphilis."

In addition to money we need an aroused public opinion, and the hearty cooperation of the medical profession. Syphilis control is not the business of the public health officer alone nor yet of the private physician, nor of the social worker. It is a job for the whole people which can be successfully done only with their intelligent understanding and cooperation. To support such action is the responsibility of a government designed to promote the general welfare of its people.

Gonorrhea, the Commonest Plague of Mankind

One authority writing on gonorrhea recently spoke of it as "one of the most formidable and wide-spread of all the dread ailments to which mankind is subject."

Another says, "There is probably no sadder phase in medicine than that presented by gonorrhea in women."

Gonorrhea seems to be at least as old as the history of man. There is evidence that the Chinese knew the disease more than five thousand years ago. The Bible describes the disease and outlines quarantine measures against its spread (Leviticus, XV). Arab, Hindu, Greek, and Roman writings indicate its prevalence among these peoples.

The seriousness of gonorrhea and its far-reaching effects in human suffering and woe are little appreciated by the public. Among men in general it has been largely looked upon as not a serious malady, not more so than a bad cold, for example, one that many people must

have and go through with, and which can usually be left to cure itself. However, the dangerous character of this disease has come to be better and more widely understood. Still, the less intelligent class still rests under the delusion that it is harmless, and gives it little thought. This misconception is a great barrier to its successful control and treatment. Every case of gonorrhea requires prompt and expert medical attention for the safety of the patient and for the protection of others against infection.

We have striking evidence of the need of informing the public about the venereal diseases. In a series of medical surveys of communities, 2,715 young men were interviewed on the streets, in pool rooms, barber shops, and other places of casual contacts, to learn what they would advise one to do who is infected with a venereal disease.

Forty-eight per cent of these young men suggested applying to a drug store for prescriptions of a remedy or a patent medicine for self treatment; 4 per cent recommended going to a herbalist; 5 per cent felt that gonorrhea did not need any treatment at all, that it would cure itself; 39 per cent suggested going to a doctor or a clinic; 4 per cent had no suggestion to offer. This means that 57 per cent of these young men gave bad advice and 39 per cent gave good advice.

It is difficult to secure reliable data as to the prevalence of gonorrhea in the United States today. It is believed, on the best available evidence, that gonorrhea among males of army age is three to five times as prevalent as syphilis. For the general population the evidence indicates a somewhat smaller ratio. Taking twice the prevalence as a fair estimate, this would mean approximately 12,000,000 gonorrheal infections at any one time. In a group of nearly 100,000 enlisted men stationed in the United States it was found that the average loss of time for sick leave per case was greater for gonorrhea than for any other disease. As in syphilis, so in gonorrhea, untold damage results from the deceptiveness of the malady. In all cases the disease tends after its acute stage to pass into a quiescent stage where there may be no real evidence of its presence. It is in these quiescent stages that gonorrhea is most dangerous. In women the disease is peculiarly misleading.

In any communicable disease and especially one so dangerous as gonorrhea, the primary emphasis belongs upon prevention. Fortunately, gonorrhea is definitely preventable. The surest preventive, both of syphilis and gonorrhea, is avoidance of promiscuous sexual contact. The effectiveness of chemical prophylaxis was demonstrated on a large scale in the United States Army during the World War, where preventive treatments were applied immediately after exposure.

The effectiveness of preventive measures used in the Army are as follows:

"In the year 1905 there were 180 cases per 1000; in 1913, 89 cases per 1000; in 1917, 107 cases per 1000; in 1920, 79 cases per 1000; in 1932, 42 cases per 1000. Army rules and regulations are stricter and more easily applied than in public life. But the above results show what can be done by strict regulations and intelligent treatment. The Advisory Committees to the United States Public Health Service has recommended that the Public Health Service carry out a thorough study of public health educational programs and methods. Such a study should include the usefulness of the radio, the press, motion pictures pamphlets and posters, lectures, exhibits, and other methods in the educational program. There is now a wealth of practical experience in the use of these media in general, but little accurate knowledge of the principles, practices and results of popular education pertaining to the venereal diseases."[1] This study should be conducted by recognized experts in the field of publicity.

1. U. S. Public Health Reports.

DISCUSSION

Dr. T. M. Rivers, Kissimmee:

There is perhaps a great change made in our expectancy tables by venereal diseases. In other words, the expectancy of the people of the civilized countries would be extended considerably if these diseases could be stamped out. Much of the harm that comes from the diseases comes from the treatment. In cases of males who come to us after years of suffering from stomach trouble, some suffering from a chronic stomach disease, careful investigation will show that this is due to drugs taken many years prior to the time—the drugs like our balsam copavia and other drugs injurious to the stomach. In like manner, many of the cases of urethral stricture may be traced to the disease itself or to the

injurious effects of the drugs. In many people who die from prostatic troubles, these prostatic diseases might have been prevented if venereal disease had been controlled.

As to gonorrhea in women, we all know only too well how they come to the clinics and to the hospitals suffering from an acute vaginitis, salpingitis, endocervicitis or other genito-urinary disturbances from which they become life sufferers and perhaps their lives are abbreviated.

As to syphilis, the many cases that we come in contact with in general practice simply teach us the injurious effects that result to the sufferer by our own neglect. We have certain laws to protect the public and the laws are good but they are not what they should be. Before one can serve at the table in a restaurant or hotel or any public place, she must have a certificate from some physician showing that she is free from these diseases, and this should be extended to nurses, physicians, teachers and to all others who are contacting the public in such a manner as to extend these diseases. Again, there should be a penalty to these laws. Too many of us physicians are signing these certificates carelessly. We have a friend who wishes to serve at a table and if we refuse to sign the certificate without a blood test, she goes over to the neighbor and he signs it for her. I say there should be a penalty to force us to make these tests. The tests are good; the laws are good and the laws should be enforced. Many things might be said along these lines but it is useless to discuss them further.

Dr. J. S. Spoto, Tampa:

I wish to thank Dr. Palmer for his most excellent and timely paper. No one realizes better than the medical profession the devastating effects of the disease syphilis and it behooves every member of the Florida Medical Association to do his share in the control of this great plague. Let's take away one thought in mind; and that is, that syphilis control is not a problem solely of the United States Public Health Service, nor a problem solely of the State Board of Health, nor a problem solely of the Social Welfare Agencies, the physicians, or the Health Department. To control syphilis, we must combine all our forces, pooling our efforts and finances, in order to attain ultimate results.

Those of us in the field of public health realize that it would be useless to attempt a syphilis control program unless we have the cooperation of every member of the Medical Society. In Hillsborough County, we have joined hands with the Medical Society in working out a syphilis control program. I would like to take up some of the phases of that program. One of the most important phases of the program is education. The educational program will be sponsored jointly by the Medical Society and the Health Unit. That, of course, will include newspaper articles, radio talks, distribution of literature, exhibits and we are also planning on having a "Syphilis Day." On that designated date, we hope to use every means available in bringing the subject before the public with intense force. Another phase of the program will lay emphasis on case reporting. We all know how very few cases of syphilis are reported. Without the reporting of cases by the physicians, a control program will be greatly crippled. We hope in the future that doctors will cooperate in reporting all cases of syphilis. The program also makes provision for epidemiologic investigation of early cases, and the necessary follow-up work. In Hillsborough County, we have five health centers distributed in the county, where syphilis conferences will be held. A physician will be in charge of the conferences, who will make the necessary physical examinations and take the necessary laboratory specimens for analysis. He will also act in an advisory capacity to the patient.

In attempting to control congenital syphilis, we have made it a routine in our Maternal Health Conferences, to do a Wassermann test on every prenatal case admitted. Our nurses are striving very hard to get the prenatal cases in the physician's office or the clinics. For if all the prenatal positive cases can be put under treatment before the fifth month of pregnancy, congenital syphilis will be a thing of the past. The treatments we are leaving entirely to the medical profession. Every case of syphilis that we find will be referred to the family physician. If in the opinion of the family physician, that case is indigent, the Unit will furnish to him the necessary arsphenamines and bismuth, which is furnished to the Unit by the State Board of Health. In Hillsborough County, we feel that we should not attempt to set up any curative clinics, at least until this arrangement has been given a fair trial.

UNUSUAL CLINICAL MANIFESTATIONS OF SOME BRAIN TUMORS*

Lucien Y. Dyrenforth, M.D.,
Jacksonville.

Certain tumors of the brain present signs which are more or less well known and understood, such as those which are diagnosed rather promptly from classical neurologic symptoms; but a few are characterized by findings which are remote from the ordinary diagnostic procedures, and among these are two which have been selected as prominently different from the ordinary.

Part I—The first of these is the definite neoplastic entity known as oligodendroglioma. This tumor was first described only ten years ago by Bailey and Cushing. While it is relatively rare, it is a slowly growing tumor that lends itself favorably to surgical removal. This alone makes it of interest as a matter of discussion, although there are other points of interest, too.

Pathologically these oligodendrogliomas are tumors of the glioma group which are usually found lying laterally in the cerebral hemispheres, but sometimes occur in the midline of the brain. Although not characteristically invasive, and having normally narrow zones of delimitation between tumor and healthy tissue, they sometimes invade the walls of the ventricles. They are practically always unilateral in occurrence. The characteristic cell is the oligodendrogliocyte. These tend to be uniform in appearance, varying somewhat as to size. They consist of rounded, almost naked nuclei, the sparse cytoplasm tending to stream outward into processes that form a network or reticulum which supports the cells. Sometimes there is a clear zone surrounding each cell, where the matrix has been pushed away. This, too, is quite a uniformly occurring microscopic picture. Differential staining with Mallory's connective tissue stain, with VanGieson's stain, with musicarmine, and with Laidlaw's stain gives certain characteristic results that are of interest principally to the pathologist.

The most important finding, and that with which we are here primarily interested, is the presence of lime salts in these tumors. Even in the earliest forms they tend to become cystic, and promptly form calcareous deposits which are opaque to x-rays. This condition is of importance in the demonstration of such a tumor, for the age incidence (which is characteristically varied) offers no relationship to the calcifying tendency. In fact, calcified areas have been found in 16-year old subjects suffering from cystic oligodendrogliomas. Ordinarily this calcification occurs independently of the blood vessel walls, and in the stroma of the tumor.

The presence of characteristic opacities in x-ray photographs of this brain tumor is significant enough for diagnosis, particularly since it is a cerebral type of growth. Figure 1 is a photograph of the gross specimen from a case brought to autopsy without a diagnosis having been made antemortem. In fact, only the brain was submitted for examination, the patient having died at some distance from a medical center (Jacksonville). X-ray photographs of the specimen reveal characteristic opacities. The lesion occurred in the left cerebral hemisphere, occupying an area the size of a billiard ball superior and lateral to the lateral ventricle in the parietal region. Its substance was soft, with areas of calcification and cystic degeneration which were responsible for the visible discolorations. The right side of the brain was uninvolved. (Fig. 1, upper).



Fig. 1, Case I, Oligodendroglioma occupying parietal area of left cerebrum.

*Read before the Chattahoochee Valley Medical Assn., Albany, Ga., July 14, 1936.

In Figure 2 are demonstrated microscopically the characteristic areas of calcification. This is characteristic of this tumor because it is a slowly growing affair, peculiarly located. In this photomicrograph, too, the typical histologic picture of oligodendroglioma is shown. While ventriculograms might help to localize such growth, they would not diagnose it. This is possible roentgenologically because of the calcium content. It is also true that other tumors may become calcified, but this is unusual; and again, the age incidence of oligodendroglioma and the attendant symptomatology tend to bring out the specificity of the roentgenographic picture.

The other clinical findings must, of course, be considered, such as papilledema of low grade, xanthochromic cerebrospinal fluid, increased intracranial pressure (due to the tendency of this tumor to grow along the lateral ventricle walls and invade the fourth ventricle) and various neurological signs. But while these are characteristic of numerous brain lesions, the x-ray demonstration of calcific deposits in a cyst-like formation in the cerebrum, ordinarily unilateral, would be diagnostic of this particular tumor. In view of its operability this is considered an important item.

Part II—The other brain tumor manifestation offered for consideration is that of peptic ulcer. More specifically this is a lesion of the prepyloric area which sometimes accompanies

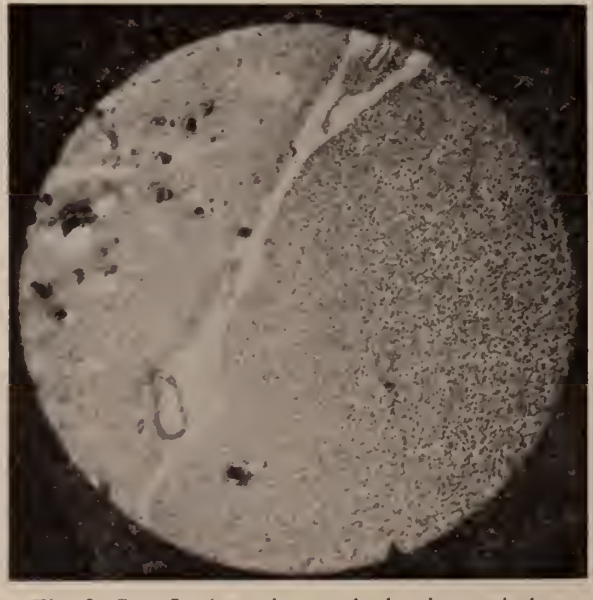


Fig. 2, Case I, photomicrograph showing typical cytology of oligodendroglioma and calcification of an adjacent cystic area. (X100).

trophic disturbances in the gastric mucosa; or which promotes a dyscrasia of the acid- secreting cells that impairs the integrity of the mucous membrane.

In discussing the pathogenesis of gastric ulcer it must be remembered that separate and apart from the central nervous system type of involvement, there is recognized a closely related neurogenic theory of origin. But this has to do with damage to the extra-nuclear vagus and sympathetic systems,—i.e., beyond their brain stem origins; whereas, the idea here involved is that of brain damage, specifically from neoplasm, and the resulting influence upon the gastric secretion.

As stated by Held and Allen (1930), to this group are related, also, the experimental results with pharmacological methods, namely, injuring the base of the brain by injecting adrenalin into animals and causing overstimulation of the sympathetic system with the production of gastric and duodenal erosions.

Light, Kendall and Bishop (1930) produced gastric lesions in rabbits by injecting pilocarpine into the cerebrospinal fluid.

From observations made upon postoperative brain tumor cases, as well as upon experimentally produced lesions, Cushing (1932) made several interesting deductions. A parasympathetic center in the diencephalon or interbrain is suggested, from which fibre tracts pass backward and form a relay with the nucleus of the vagus nerve, among others, and this, therefore, accounts for the influence upon the alimentary canal of lesions in this area. Furthermore, Cushing finds that lesions anywhere along the course of these fibre tracts, from anterior hypothalamus to vagal center, may cause gastric lesions. The result may be from parasympathetic stimulation, or from "vagal release" due to sympathetic paralysis. Since intracranial injuries and diseases of this portion of the brain are known to produce lesions of the gastric mucosa, this author concludes that such conditions following certain of his cerebellar operations are of identical nature. In this important paper Cushing goes into the many phases of this subject in detail, both anatomical and pharmacologic. He even goes so far as to say that this evidence, of a medullary center involvement, or a midor interbrain involvement, may well explain the presence of "a long overloaded station for vegetative impulses easily affected by psychic

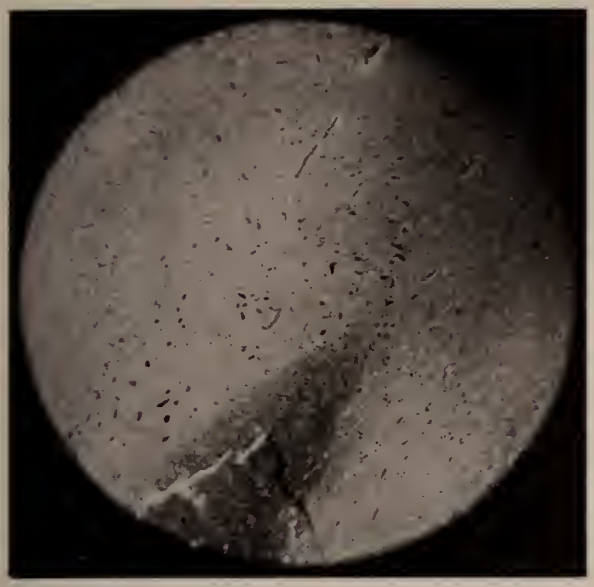


Fig. 3. Case II. Photomicrograph of spongioblastoma polare, with characteristic web-like stroma containing spongioblasts, and an area of hemorrhage. (X100).

influences . . . . . that highly strung persons . . . . . of nervous instability classified as vagotonic . . . . . are prone to have chronic digestive disturbances with hyperacidity often leading to ulcer." This paper adequately stresses the fact that brain tumors are frequently the cause of this condition whether directly, by mechanical influences, or indirectly, by reason of surgical influences.

It is, of course, unnecessary to point out grave dangers which face the neurosurgeon in operations on the areas mentioned. The endocrine background of peptic ulcer is brought out by Comroe (1933)[8] in describing gastric lesions associated with hypophyseal pathology. He makes the suggestion that early ulcers be treated with pituitrin subcutaneously. Dodds, Hills, Noble and Williams (1935) have also added to the experimental evidence of a hormonal influence in the production of chronic ulcers of the stomach. Grant (1935)[9] in two case reports corroborates the work of Cushing. Hoff and Sheehan (1935)[11] working with monkeys produced multiple hemorrhagic erosions in the stomach by means of injuries to the hypothalamus.

Case—William A., fifty year old white printer entered the hospital on January 9, 1936, shortly before noon. He expired that same afternoon about 3:30. On entry he was breathing stertorously, was unconscious, and had a blood pressure of more than 300 systolic, 120 diastolic. He had a previous history of several attacks of epigastric distress which were accompanied by intense pain. He had been a heavy drinker of alcoholic stimulants in youth. In the present instance the patient was seized with a severe abdominal cramp while at work, and collapsed. There was no history of hematemesis, but the stools had been tarry and gave laboratory proof of profuse blood pigment content. No dietary regime had been followed, but the patient was known to have taken as much as a pound of sodium bicarbonate over a period of three to four days in the effort to control epigastric pain.

Upon examination, the right pupil was found to be smaller than the left. Both reacted sluggishly to light. The abdomen was not rigid or distended. The blood pressure dropped gradually until exitus. A urinalysis showed many erythrocytes, was of low specific gravity, and was alkaline.

The autopsy record was essentially negative except for the brain and stomach, some dense pleural adhesions, an eccentric cardiac enlargement, and atheroma of the large vessels.

The stomach contained an indurated area with a slight puckering of the exterior surface about ⅓ of the distance from pylorus to cardia, on the greater curvature. There were no glands or masses, except for two small nodes near the celiac axis. The mucous membrane of the area noted contained a punched-out ulcer 5 mm. in diameter, extending through to the muscle. Its periphery was red.



Fig. 4, Case II. Photomicrograph of ulcer edge in stomach.

The rest of the stomach appeared to be normal.

The brain was of average size. Its suface convolutions were flattened. The left lateral ventricle was completely filled with blood clots, which extended into the third ventricle, the aqueduct, and the fourth ventricle as well as the first portion of the spinal canal. The lateral wall and floor of the left lateral ventricle seemed very soft and friable, as if from a neoplasm.

The final diagnosis was a follows:

Spongioblastoma polare of the left cerebral hemisphere with rupture and hemorrhage into the ventricles; gastric ulcer; chronic glomerular nephritis; parenchymatous degeneration of the heart, liver, kidneys; eccentric hypertrophy of the heart; decreased lipoid content of the adrenals; moderate generalized arteriosclerosis; pleural adhesions.



Fig. 5, Case I, X-ray photograph of brain showing opacities in left cerebral hemisphere due to calcified cystic oligodendroglioma. (The brain which was removed at autopsy was bound in gauze after examining, and the x-ray photograph then obtained).

Microscopic examination of the stomach ulcer (Fig. 4) showed a typical picture with sloughing edges, sharp demarcation and infiltration by leukocytes of the surrounding areas. In the brain tumor (Fig. 3) there are seen the characteristic cells of the spongioblastic element, unipolar and bipolar. These cells occupy an indifferent matrix which strains poorly with hematoxylin-eosin, being a pale pinkish cytoplasm with ill-defined nuclei. An area of hemorrhage can be seen at one edge of the slide. The central portion of the tumor was soft and hemorrhagic. Although this tumor is classed as a benign neoplasm, it frequently attains malignant dimensions, especially when it infringes upon vital areas and breaks down. In this instance it undoubtedly involved portions of the pathways which influenced the gastric pathology.

SUMMARY

The importance of certain regularly occurring pathological manifestation of some brain tumors is discussed in connection with two cases which illustrated the diagnostic features, namely, calcification in cystic oligodendroglioma, and the association of gastric ulcer with brain tumor.

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DISCUSSION

Dr. J. G. Lyerly, Jacksonville:

Dr. Dyrenforth's two case reports are extremely interesting. They represent two of the rarer forms of glioma, both of which are not highly malignant, as we usually recognize them.

The oligodendroglioma is a tumor composed of a type of cell derived from the neuroglia and is found in the temporoparietal and sometimes in the frontal region of the cere-

brum. It is a solid tumor and grows beneath the cortex and usually has calcifications deposited in it which may be demonstrated by x-ray. It is a favorable type for operative removal, and because of its slow growth the patient may obtain a long period of relief should it recur.

The spongioblastoma polare is also a slow growing glioma. Its favorite location is in the region of the basal ganglia, brain stem, and pons, which renders it unfavorable for removal. Sometimes it occurs in the cerebellum when it may be cystic, containing a mural nodule of tumor which if removed may effect a cure, as is the case of astrocytoma. The interesting feature in this case is the associated peptic ulcer apparently due to involvement of the anterior hypothalamic region where the parasympathetic centers are located.

Cushing and others have reported cases of tumor involving the brain stem in the hypothalamic region associated with gastric ulcers. A good deal of experimental work has been done in the past five years apparently establishing a center for parasympathetic function in the anterior hypothalamic region and another center for true sympathetic function in the posterior hypothalamic region. The anterior hypothalamic region is closely associated with the posterior lobe of the pituitary. Lesions of this region frequently have disturbance of metabolism, of fat carbohydrates and water, causing obesity, and diabetes insipidus. There may also be disturbance of temperature regulation and the sleep mechanism.

Tumors in the region of the third ventricle are notorious in producing some unusual clinical manifestations. The supracellar cyst in the child may be associated with bed wetting and polyuria, and stunting of body growth due to impaired function of the pituitary gland, and sometimes a hydrocephalic head.

With intraventricular tumors or cysts there may be sudden headache, vomiting or unconsciousness due to blockage of the cerebrospinal fluid drainage from the ventricle. There may be fever, tremors, and sweating due to disturbance of the hypothalamic region. This may lead the inexperienced diagnostician to make the diagnosis of malaria or encephalitis, which mistake is too often made in brain tumor.

I think it is an excellent idea to report these unusual manifestations in brain tumors so that they may be recognized in the early stages and that the patient may not be treated for conditions which he does not have.

Dr. J. Calvin Weaver, Atlanta, Ga.:

Dr. Dyrenforth's paper is very timely and very enlightening.

For several years neurologists have been hammering on the classical symptoms of brain tumors, trying to get the general practitioner brain tumor-minded. That being pretty well accomplished, Dr. Dyrenforth steps in and carries us a bit farther by showing that lime deposit and symptoms of increased intracranial pressure not only mean a tumor, but tell the type of tumor as well as the prognosis.

He also impresses distal complications that may be anticipated in lesions of the interbrain, such as a stomach ulcer; well, indeed to know. This prompts me to discuss his paper from still another angle.

There are only two reasons for a paper to be discussed. One is to drive home the points the essayist has made; the other is to add something which time did not allow him to offer.

I wish to lead your mind to unusual conditions producing symptoms of brain tumors.

If we will remember that there is an interrelationship between the different systems of the body, it will be easy to see that brain symptoms may result from distal pathology as easily as stomach ulcers may result from brain pathology. So a neurologist should be a good general diagnostician as well as a specialist. Little is the consolation to the patient with an intractable headache to be told that no brain tumor is present, and no more. If a patient comes with an extreme headache, nausea, fast failing vision and swelling of the optic discs, don't jump at conclusions, as a fast failing sight doesn't generally come from a choked disc, rather from an inflammatory swelling of the optic nerves. Abscessed teeth can cause such a chain of symptoms. Removal of the offending teeth, plus elimination, may rapidly restore the sight and clear up the headaches and nausea.

Again, a patient may come with a history of deafness in one ear, with recent tinnitus, nausea, dizziness and horizontal nystagmus, withal a pretty picture of a pontile angle tum-

or, a most melancholy outlook at best. If that patient shows definite symptoms also of a chronic perityphlitis, before doing a brain operation, remove the appendix and mobilize the cecum and await developments. I have known such a picture to fade away.

These actual cases are mentioned to encourage you to assume an analytical attitude and to think along more than one line.

CARE OF SURGICAL PATIENTS*

WALTER C. JONES, M.D.,
Miami.

The discussion of this subject will be centered principally around surgery of the abdomen, and presupposes that preoperatively there has been a thorough study made of the case with a working diagnosis, and that during the operation a careful technique has been used. The surgical crises postoperatively are dependent upon the severity of the case, the care used during operation and the judgment exercised after the operation. Of these three factors the first is uncontrollable; however, the latter two are dependent upon the experience of the surgeon and to some extent controllable.

The cases seen fall into two main groups, emergency or elective. All emergency cases are necessarily not prepared sufficiently preoperatively and are more prone to postoperative complications, especially infection. Sterilization of skin surfaces is impossible since there is no perfect antiseptic. Hence, preparation of the skin should be begun at least twelve hours previously in order to expect an approach nearing asepsis. This is not possible in acute emergencies and more abdominal wall infections may be expected in this group. Likewise, in these cases it is not possible to prepare properly the gastro-intestinal tract. No preliminary residue-free diet has been used. Of course no purgative should ever be given, and only in the milder forms should a low warm saline enema be administered prior to operation. If the public, and unfortunately some of our own profession, fully realized that in acute abdominal pain no purgative should ever be given until diagnosis is established and then only if the need for surgery of the abdomen can be eliminated, the mortality rate in acute abdominal surgery would fall to a proper level. Rarely does an appendix rupture unless violent gastro-intestinal stimulation has occurred; the majority of peritoneal infections tend to localize if the patient is left at rest without enemata and splinted by action of morphine; but a localized peritonitis may become a violent spreading type after use of a purgative or enemata. The more severe forms of emergency are seen in a marked degree of shock associated with marked dehydration. This state should be combatted if successful surgery is to be accomplished. This is far more important at such a stage than madly rushing into surgery with a patient in a dying state. Except in severe hemorrhages where it is frequently necessary to act after a preliminary transfusion, which should be continued during the operation, it is astounding how these cases of severe shock respond to rest, fluids and morphine. The question of time of operation in acute appendicitis with spreading peritonitis is debatable, however; it seems to center around the differential diagnosis of local or spreading peritonitis, which is difficult to make.

As a rule, it seems wise to remove a focal point of infection as soon as possible. A ruptured peptic ulcer is closed upon diagnosis after relief of shock and it would seem much more difficult for localization of a ruptured appendix without removal than after removal. This statement is based upon experience of the past where localization without operation, drainage alone, and removal with and without drainage, have been used, also being fully cognizant of the excellent work done on appendicitis by Bowers and his associates. If there is a well-defined spreading peritonitis already generalized, surgery can be of no avail but, as said before, this has been a difficult differential diagnosis to make from localized peritonitis.

In the elective cases the preoperative preparation has a distinct bearing on the postoperative course. Many a worry after operation could have been eliminated by a careful study before operation. Routine blood studies should always be done with particular interest in anemia, leukemia and various blood dyscrasias. Urinalysis not only may be of value

*Read before Dade County Medical Society, Miami, Jan. 5, 1937.

in diagnosis but a warning as to a serious renal, diabetic or cardiovascular-renal complication. A thorough physical examination may reveal abnormalities which should be remedied before surgery is undertaken. The more detailed studies will be indicated in the individual case dependent upon the above findings. At least 24 hours prior to operation the bowels should move normally, aided if necessary by a mild laxative. No heavy purge should be used. Long since purgation has been known to be an etiological factor in postoperative distension. Following normal elimination the patient is kept on liquids which are high in carbohydrate value. The fluid intake during the last preoperative day should be at least 3000 cc. aided by parenteral intake when needed. Two to four hours preceding operation the colon should be emptied by a low enema. In gastric surgery the stomach should be thoroughly washed at least twice during the twelve hours before operation and preferably a nasal tube left in place. If dilatation and hypertrophy are present a normal tone must be obtained by repeated lavages for days. In surgery of the colon the period of preparation and use of residue-free diet must be prolonged for days until a fairly normal bacterial state exists, which is present in a few days after relief of obstruction and its dilatation. Should the obstruction be complete, a preliminary decompression must be done before surgery of the colon is attempted. Immediate operations on the obstructed colon are doomed to a prohibitive mortality rate and excessive morbidity. How easily a cecostomy may be done in such cases and how gratifying to see the patient following decompression of the bowel, relieved of the toxicity, and in a short while in suitable condition for corrective surgery.

The patient should reach surgery in a calm sleepy state aided by barbiturates and opiates, and preferably in an amnesic state, as produced by basal anesthesias. A highly nervous, excitable patient requires far more anesthesia during an operation. The reaction of an individual to fear has frequently been observed and is evidenced by pallor, rapid pulse, gastrointestinal phenomena, and other symptoms of disturbance of the sympathetic nervous system. It is not definitely known how much more vulnerable the sympathetic nervous system is in such a state to effects of trauma but it is reasonable to feel that this is a factor in production of shock and that protection of the psychic may be a factor in the prophylaxis against shock. The amount of anesthetic may also be decidedly lowered by blocking the field of operation with local anesthetic (Novocain 1-200), which also lessens the trauma to the comatic nervous system.

During the operation sharp dissection, careful hemostasis, and gentle manipulation are essential to a normal convalescence. Undue traction is a forerunner of shock. An adequate incision for proper exposure of operative field is much less hazardous. Body temperature should be maintained as nearly normal as possible with great care as to excessive changes in either direction. Marked dehydration may be produced during our summer months from excessive perspiration. In transportation sufficient blankets must be used to prevent chilling. It would seem that air-conditioning of operating rooms would tend to remedy both these conditions, certainly the former.

The above factors all tend to bring the patient through the operation in the best condition possible for a normal convalescence. In the average uncomplicated case there is a certain course which should be followed in order to pass these first few postoperative days most comfortably. Immediately after operation good nursing care is essential. Preservation of normal body temperature is imperative. The bed should be warm with ample blankets and the room free from draughts. This may seem fairly insignificant but it should be stressed, as this is the time for the beginning of a bronchopneumonia.

Fluids are begun at once, using a minimum of 1000 cc. of glucose (2½%) solution in normal saline as a hypodermoclysis. Glucose in 5% solution may be tolerated subcutaneously. If the solution is given intravenously it should be given very slowly, 45 to 60 drops a minute, at which rate it may be given continuously. At this period the myocardium may have been severely taxed and sudden failure is a possibility. Nothing should be given by mouth for the first six to twelve

hours depending upon the severity of the operation. Then intake is begun gradually. Tepid water, one ounce every hour for three doses, then 2 ounces every hour for 3 doses, and so on until three ounces every hour have been retained, when fat-free broths and hot tea may be added. If there is no vomiting at the end of 72 hours a full soft diet may be given which at the end of five days may be increased to a full diet. During this gradual giving of fluids, the fluid balance of the body must be maintained. In the average case a total of 3000 cc. is required during each 24 hours. The specific gravity of the urine should be 1.015 to 1.020 and the output near 1500 cc. daily. This is a fairly accurate check as to the fluid requirements of the individual. It is preferred that parenteral fluids be given subcutaneously or intravenously. The rectal route may be used in the clean elective case but in the presence of peritoneal involvement it should be avoided.

For relief of pain opiates are doubly indicated. It was formerly thought that opiates predisposed to distension. Recent investigations have shown, on the contrary, that morphine increases intestinal tone and quiets peristalsis. For 72 hours the patient should receive an opiate as needed to relieve pain and in the peritonitis case at regular stated intervals for effect. Some individuals react untowardly to morphine and in such cases a substitution of pantopon or dilaudid may be made. Relief from pain is essential, as restless, fretful patients cannot recover rapidly. The addition of barbiturates may assist but should be used with caution.

The urinary bladder should be guarded carefully. If there has been considerable shock or dehydration the urinary output may be scant during the first 24 hours; however, it does not seem desirable to allow patients to go longer than 12 hours without voiding. A distended bladder with its numerous lacerations is a far more fertile field for infection than a normal one which has been catheterized aseptically. The presence of a mild cystitis may be benefited by an irrigation with weak silver nitrate (1:2000) solution.

Nausea and vomiting are the guides as to intestinal tonicity. Following the simplest intra-abdominal procedure there results a moderate loss of tone or ileus. The degree of ileus is dependent upon the amount of trauma intraperitoneally, whether it be mechanical, chemical or bacterial. In the presence of ileus the function of the intestine to digest and absorb liquids and gases is reversed, so that there is a secretion of fluids and accumulation of gases. In the average case there is a gradual return of tone in the intestinal tract, so that at the end of 12 hours some absorption is taking place. If nausea or vomiting develops it is a sign that there is not absorption of fluids taken by mouth, or a hypersecretion of fluids by the intestine, or both. In either case, intake by mouth should be stopped at once and if vomiting persists a nasal tube inserted for siphonage. With this in place fluids may again be given, as all excesses will be drained back; but upon return of tone nearly all will pass into the intestinal tract regardless of the nasal tube. Hence, after insertion of a nasal tube (which is not a bad procedure in all cases), measurement of the intake of fluids by mouth and the output by tube acts as an indicator of the degree of tone. Excess output by tube means hypersecretion or ileus; excess intake means absorption of fluids by the intestinal tract or return of tone, in which case the tube may be removed and fluids given gradually.

In severe cases, such as extreme trauma or peritonitis, ileus will be aggravated and accompanied by distension. Nasal tube connected with suction (Wagensteen) bottle should be begun at once. Again measurement of intake and output as above will indicate the return of tone. Upon return of tone peristalsis can be heard by auscultation. By decompression of the upper intestinal canal per nasal tube, a normal blood supply to the walls is maintained, since only a moderate intra-intestinal pressure here is necessary to shut off the blood supply to the mucosa and delay or deny return of tone. Heat should be maintained constantly to the abdominal wall after 12 hours and a fairly constant temperature is supplied by means of an electric pad.

Upon return of tone some peristalsis occurs and consequently some intestinal cramps or "gas pains." Nature is gradually winning its victory, overcoming ileus. It should be assisted at this stage by heat locally, morphine and rectal tube, and not hindered by additional

trauma. Before definite peristalsis is distinctly audible by auscultation and evidenced physically by expulsion of gas through the rectal tube, no enema should be given. At the end of 72 hours mineral oil or its emulsions may be given, in the average case, in 1 to 2 ounce doses every 12 hours. If no elimination has occurred at the end of 24 hours, no nausea developed, and peristalsis is in evidence, a low saline enema will usually give satisfactory elimination. This routine may be followed and regulated as necessary. At this time a heavy purgative will eliminate gas upon evacuation, but will likewise leave its trauma and so prolong ileus which means more distension and more "gas pains." It has torn out a healing intestinal wound and may frequently spread a localized peritonitis. Likewise, it is true that the use of enema upon the development of distension will not only remove very little gas per rectum, but so traumatizes an ailing intestinal tract that distension will actually be increased. If continued, a mild ileus may be converted into an extreme form, which has been called paralytic ileus, and even death to a patient who should have had only a mild ileus. In treatment of distension it is necessary to remember the physiological function and pathological state of the intestinal canal. Very little benefit has been derived from the use of pituitrin, pilocarpine, etc. Hypertonic salines seem to increase tonicity, but care should be exercised in their use in peritonitis. They should be given only after the disease is under control and danger of spread is past. With nasal tube suction, continuous venoclysis, heat pads and opiates, a patient may be carried through a severe ileus for days and life saved, provided there is patience to persist in such conservative treatment. If patience is lost and a rapid course sought frequently the patient also is lost.

The method of caring for the wound is dependent upon the individual case. In clean cases skin sutures may be removed in five days and retention sutures at the end of 10 to 12 days. In presence of infection, adequate drainage of the abdominal wall is essential; if necessary, sutures may be removed earlier. Abdominal wall infections are more hazardous than frequently thought.

The disability varies, of course, with the individual and the type of operation. As a rule the muscle-splitting incisions are sufficiently strong in 5 to 7 days to allow the patient to be out of bed. The midline and similar incisions require 12 to 14 days in bed. In drainage cases destruction of the wall followed by hernia is not infrequent.

SUMMARY

There are numerous complications which occasionally arise during the postoperative course. It is impossible to discuss all of these within the limits of this paper, which has been centered around abdominal surgery and treats essentially of postoperative care in the average case, putting especial emphasis upon prevention and treatment of ileus. These ideas are not original but based upon experimental and clinical work carried on during the past few years in our various centers, particularly the laboratory work done by Ochsner on postoperative ileus.

It is to be hoped some points may prove of practical value in the care of patients with a lowering of mortality and marked decrease in morbidity.

DISCUSSION

Dr. Duncan Owens, Miami Beach:

I wish to congratulate Dr. Jones upon the clearness and simplicity of his paper. I agree with his idea of using morphine, except that I leave orders for morphine every four hours for the first 24 hours and as often as necessary during the first 72 hours until the tone returns to the intestines.

I also find the use of the oxygen tent in cases of general peritonitis with distention, of great benefit.

THE UNUSUALLY LOCATED APPENDIX*

W. D. Sugg, M. D.
Bradenton

In our day, anniversaries have become rather commonplace. I do think, though, that it is fitting to call attention to the fact that it has been just a little over fifty years since a Harvard pathologist, Reginald Fitz, published in 1886 the first paper on appendicitis.

Reginald Fitz did not invent appendicitis nor did he discover the organ as I fear the average medical student is inclined to conclude. In Dunglinson's *Practice of Medi-*

*Read before the Florida Midland Medical Society, Bradenton, April 29, 1937.

cine printed in 1844 I recently discovered the following interesting paragraph:

"The appendix vermiformis, a functionless and by no means indispensible organ, may have substances impacted in it which give rise to inflammation and perforation attended with fatal consequences . . . . . The symptoms of inflammation of the appendix are by no means diagnostic. Generally there is deep seated pain and tenderness in the cecal region with more or less fever, vomiting, and obstinate constipation . . . . . Treatment consists of hot poultices, leeches, copious hot enemata, and the opening of parietal abscesses which may develop."

In Druitt's *Modern Surgery* printed in 1844 the appendix is not mentioned in the six pages devoted to abdominal surgery.

Little has been added to Reginald Fitz's description of the typical case of appendicitis by the thousands of papers which have followed his. In part he says: "Appendicitis, even in the absence of concretions or foreign bodies may progress towards ulceration, perforation, peritonitis, death . . . . Sudden severe abdominal pain is the most constant first symptom of perforative inflammation of the appendix. This is occasionally accompanied by a chill, nausea, or vomiting. The temperature is rarely high. The case may resolve or result in peritonitis beginning on the second, third, or fourth day after the onset. A cathartic may at once excite a general peritonitis."

Fitz reported 257 cases of perforative appendicitis from the dead house and emphatically urged early operation.

Nicholas Senn in his *Surgery* published in 1896 complained that during the past ten years so much surgical literature on the appendix had accumulated that the subject was thread-bare. Hundreds of papers are still being published each year on the subject in the medical press of the world. In those articles which I have found in the recent files of three of the more popular American surgical journals three aspects of the subject are developed; first, that the mortality of appendicitis is increasing; second, appendicitis is hard to diagnose and cure in the very young; third, appendicitis is hard to diagnose and cure in the aged.

My excuse for inflicting still another paper about appendicitis upon you is to report a case of gangrenous perforative appendicitis in a patient with complete transposition of the abdominal viscera.

The patient is a white male, aged 32—a mechanic. He was seen by his physician about 48 hours before operation. His complaint was pain in the epigastrium attributed to dietary indiscretion. Six hours later his physician found him still complaining of epigastric pain with tenderness in the left lower abdomen. Pulse, temperature, and white blood count were normal. Still twelve hours later the pain and tenderness remained with a leukocyte count of 9,000. Hospitalization was refused. The patient was given some sort of physiotherapy by a Tampa doctor. At the end of 48 hours he entered the hospital here with a temperature of 102, pulse 128, white blood count 20,000, large polymorphonuclear cells, with a considerable shift to the left. His belly showed marked rigidity and tenderness, especially in the left lower quadrant. Examination revealed a dextra-cardia. History suggestive of chronic phthisis, had led his physician to attribute this to pulmonary adhesions. There was history of a similar attack lasting five days 21 years ago. X-ray revealed complete transposition of the colon and cecum. At operation a left rectus incision was made. The appendix was a huge thick-walled, semi-necrotic mass with an occluded base. There was evidence of beginning peritonitis. Drains were inserted and prontolyn and prontosil were given. The postoperative course was very smooth.

Dr. Chas. Mayo reported in 1911 three cases of left-sided appendicitis where the cecum had not rotated, and was able to find in the literature of the world 300 cases of complete transposition of the intestinal viscera.

We are all familiar with the embryonic process of rotation whereby the cecum normally tranverses the upper abdomen and comes to rest with its head in the right iliac fossa. The appendix may be arrested in any position along this course. Robertson says that in over 4 per cent of cases the normal descent of the cecum is not completed. If the appendix does not completely rotate it drags behind the cecum and becomes retroperitoneal and retrocecal. Once the caput of the cecum lies in its bed the position of the appendix may vary in the same directions radially as the

hand of a clock. Deaver with his 50,000 appendectomies stated that 60 per cent lay laterally or behind the cecum. Most authorities state the majority point inward and upward or hang over into the pelvis.

I recently operated on a young man who had been under treatment for duodenal ulcer for a year in the North. He was taken acutely ill, with symptoms of typical appendicitis, except for the fact that his pain and tenderness was in the right hypochondrium. A high right rectus incision revealed a very acutely involved appendix stretched medially across the abdomen from a high cecum. A physician inclined to out-wait the acute gallbladder might get into most serious trouble in a case of this sort. The cecum may descend into the pelvis or with increasing age slide into the pelvis carrying the appendix along, or a long appendix may hang quite deep in the pelvis. In the case of a sliding hernia or under other conditions the appendix may appear in an inguinal sac. I have twice seen gangrenous appendicitis in an inguinal hernia, diagnosed once as strangulated intestine, and once as torsion of the testicle. These were not my cases.

Dr. Brunn of San Francisco published a paper in the December number of the *Journal of Surgery, Gynecology and Obstetrics* on pelvic appendicitis which every man having to make abdominal diagnoses should read carefully. I am taking the liberty of making sketchy abstractions from his article. Dr. Brunn, says, in part: "Ninety per cent of the cases of ruptured appendix referred to me are cases of pelvic appendicitis. The onset is with umbilical or epigastric pain. Localization is more frequently to the left than to the right side of the pelvis. Vomiting may ensue, particularly if a cathartic is taken. At first examination there is usually a normal temperature, a flat soft abdomen, without rigidity, and often without tenderness. Often there is irritation on urination, and frequency. If the appendix is very low there may be also a rather constant desire to move the bowels. Frequently red blood cells are present in the urine. The white blood count is usually 15,000 to 20,000.

"Rectal examination should be done thoroughly on a hard table. In early cases tenderness may be made out with definiteness and rectal examination should be repeated until a final diagnosis is made. Salpingitis, hemorrhage from an ovarian follicle, and right ureteral stone must be ruled out."

Dr. Brunn states that his chief diagnostic point from salpingitis is that in acute salpingitis there is a marked hastening of the sedimentation time, which is not found in appendicitis until peritonitis or an abscess develops. My own experience with the sedimentation time is too limited to express an opinion.

Out of a group of something over a hundred acute appendix cases of my own which I recently went over, three of six deaths were in cases in which advanced peritonitis was present at the time of operation. The three patients who were seen in a stage preceding advanced peritonitis but who were subsequently lost were elderly people with pelvic appendicitis. Two of these cases, I wish to report as they show the ease with which I fell into the diagnostic pitfalls which beset this condition.

The first case was a white female aged about 70, first seen with her physician six days before her entry into the hospital, in May, 1933. Onset was pain in the left shoulder and epigastrium. Abdominal and rectal examination revealed no tenderness, except possibly in the upper left abdomen. There was no rigidity. The temperature was 100; the white blood cell count was 11,000. The urine contained casts. Her physician kept her in bed under observation. The condition did not appreciably change and on the fifth day, on her own initiative she took calomel and salts. The following night she was seized with severe pain in the rectum. The following morning she had a white blood cell count of 15,000, pulse 110, temperature 101, a little abdominal tenderness but moderate rigidity, low. Rectal and vaginal examination revealed a tender pelvic mass. A diagnosis of ruptured appendix was made. A low right rectus incision revealed a necrotic sloughed-off appendix in a small foul-smelling abscess lying on the rectum, with spreading peritoneal infection. Copious drainage was instituted. Ultimately the wound healed but the patient died on the one hundred and twelfth postoperative day.

The other case was a white male aged 60 seen in 1935. Onset was with severe lower abdominal pain which had practically cleared

up when I first saw him two hours after the onset. There was a little tenderness right above the pubis on the right side. The history, which was elicited over a period of twenty-four hours as the patient seemed to wish to present his case as a puzzle, was that he had a similar attack several months before for which he had gone to a hospital in the North. Various x-ray and cystoscopic studies were made, the final diagnosis being enlarged prostate, ureteral stricture or soft stone in the lower ureter, and slight spina bifida. He had been seen on the day previous to my first visit by another physician, his complaint being rectal or lower pelvic discomfort. He was given diathermy treatment of the prostate and referred to a urologist for a prostatectomy, for enlarged prostate. The white blood cell count was 10,000, and there was some pus and microscopic blood in the urine. Rectal examination revealed what looked to be a large tender prostate, but catheterization revealed no urinary retention. Temperature was normal. I warned the patient that the trouble might possibly be appendicitis and advised against taking food or purgatives and advised him to stay in bed.

The following day the patient's symptoms were improved; he was up going around when I visited him, although he still had a blood count of 11,000. He felt that he did not require further medical attention and I did not see him again for four days when he walked into my office. At that time he was apparently quite ill, with temperature of 100, white blood count 14,000, slight tenderness just to the right and above the pubis. Rectal examination revealed what felt like a very large tender prostate of acute prostatitis. The urine was negative. Fluoroscopic examination of the colon revealed a cecum lying very low in the pelvis and a diagnosis of a small appendiceal abscess lying on the rectum was made and confirmed at operation. Drainage was instituted. Death occurred in about three weeks as a complication of the drainage I believe.

I believe, had I been familiar with Dr. Brunn's recent paper at the time I saw the two cases, I would not have been so slow to recognize the true situation.

I still do not know what to do with these cases when first seen in these advanced states. Dr. Brunn says not to drain, as drainage through the uncontaminated abdomen is dangerous, but to close up after the removal of the appendix and wait for a pelvic abscess to form to be opened through the rectum if necessary. At the Mayo Clinic last fall I saw an operator using a extensive quarantine type of drainage in a case somewhat similar.

THE PUBLIC HEALTH APPROACH TO CONTRACEPTION

LYDIA ALLEN DEVILBISS, M.D.,
Miami

During the 25 years of its activities in the United States, the contraceptive movement has gone through two distinct phases: the popular and the medical. It is now entering the third and perhaps the last stage. This is the public health approach or the use of scientifically applied contraception as a factor in reducing morbidity and mortality.

Neither birth control propaganda nor birth control clinics reach that large portion of the population where the need for contraceptive advice may be most urgent. On the contrary, in practice contraception has been utilized to the largest extent by those families who are perhaps best fitted to bear and rear children. The birth rate among the comfortable income classes (estimated at $2,500 annually) for the years 1928-32 inclusive was 110 per 1000 married women of child bearing age. For those families wholly supported by charity (with a high percentage of disease and degeneracy) the birth rate was 207.[1]

The value of scientifically applied contraception in reducing morbidity and mortality rates has not been accepted by a majority of the medical and public health professions. It is possible, however, that control of inheritance in addition to the established hygienic control of environment may prove to be basic in reducing preventable sickness and death.

In the consideration of maternal mortality it is accepted that women who are suffering from tuberculosis or heart or kidney ailments are more apt to suffer serious injury or to lose their lives in pregnancy than women who are in normal health. It is therefore entirely reasonable to assume that if women who are in such poor physical condition as to be classed as poor maternity risks were to be given protection from pregnancy until such time as their health warranted the attempt to bear a

child, the maternal mortality rate would be reduced.

To determine whether and to what extent protection from pregnancy for poor maternity risks would affect maternal mortality an experiment was begun in Dade County in 1932.[2] For the purpose of this study, a poor maternity risk was defined as a woman who could not bear a child with safety to the life and health of mother and baby. During the four-year period, 1932-35 inclusive, contraceptive advice was given to more than 1200 white women most of whom would be classed as poor maternity risks. The maternal mortality rate for Dade County for resident whites was 8.4 in 1932. In 1935 it was 4.2. During the same four-year period the resident white maternal mortality for the State of Florida was reduced from 8 to 7.3.[3]

In order to reach that large number of indigent sick women who perhaps need contraception most, some method other than that customarily employed by contraceptive clinics was found desirable. Following public health procedure in the control of other problems in hygiene, a case worker was employed to visit these women in their homes. In order for her work to be most effective and to reach the largest number of indigent sick women in the shortest period of time, a simple, inexpensive contraceptive was necessary. Something was needed which did not require the administration of a physician and which the case worker, under the supervision of a physician, could use to instruct women in their homes.

Soap has long been known to be an effective spermaticide.[4] The experiment with various forms of mild soap, however, produced many irritation complaints and resulted in admitted non-use pregnancies. Experiments were then begun with soap substitutes such as are used for the foaming element in certain types of tooth pastes and for other purposes. The chemical selected for this purpose has the formula of $C_{13}H_{27}OSO_3Na$. This was combined with a protective colloid and 1 part in 250 paraformaldehyde (oxythemethline) to prevent mold. Paraformaldehyde 1 part in 256 is reported also as an effective spermaticide.[5] This formula produces a copious foam which is stabile. In order to provide the necessary moisture to produce the foam and as a convenient method of introducing foam into the vagina previous to relations, a small sterilized sea sponge was selected after tests of many varieties of rubber and natural sponges.[6]

A Technical Committee was appointed to direct and supervise this experiment.[7] Samples of the formula were submitted to laboratories for spermicidal reports.[8] Two laboratories reported that on contact with the foam an immediate marked reduction in motility was observed and all motion stopped at periods varying from 60 to 90 seconds.

Tests for the possibilities of irritation on mucous membranes were carried out independently in two laboratories.[9] The first experiments were made on the vagina of the bitch. Due, however, to the many differences between the vagina of the dog and the human, the opinion was that tests on the dog were not conclusive for comparative data.

Tests for irritation were then conducted independently using the dogs' conjunctivae. A small quantity of weak lactic acid was placed in both eyes and one held as a control. Various amounts of foam were introduced into one eye, daily and twice daily, for six days. Only one young dog on the sixth day showed signs of irritation which promptly cleared up when the foam was discontinued.

A series of women who had been using the formula for several months was also examined. Careful observation failed to discover any irritation. Two cases of irritation complaints were found to be the result of excoriated labia in women who were overweight and two other cases were cleared up by cauterization of the cervix.

The experiment with white charity patients was begun early in 1935. Patients were instructed in the use of sponge and foampowder in their homes and at the Clinic. A careful case history was taken and reviewed by the physician in charge. All cases in which there was any complaint or in which the case record indicated need for medical or surgical care were examined and referred to the physician or agency for care. Insofar as was possible all cases of reported pregnancy were also examined. In four pregnancies occurring among white patients large cervical tears were discovered. The work among the colored in Dade County began in May, 1935, and continued to June 1, 1937. Whenever patients were found to be of such low average intelligence that they could

not cooperate consistently, such families were recommended for sterilization.

TABULATION OF RESULTS

The efficacy of contraceptive methods is computed in terms of 100 person-exposure years. To obtain this figure, the total number of months is divided by 1200. The number of pregnancies divided by the number of 100 person-exposure years gives the pregnancy rate.

In a study of all methods used and for all families, Stix and Notestein[10] report a pregnancy rate of 27. The pregnancy rates for the formulas used in the Mothers Health Clinics compare favorably as to results.

TABLE I

White—Dade County, Florida

1. Cases
   - Number cases at beginning of experiment, May, 1935 27
   - Total case histories as of September 1, 1937 431
   - Cases eliminated, using formula less than 6 months 228
   - Total net cases reported for this tabulation 203
2. Months used
   - Total months used to pregnancy 303
   - Total months used all cases 2498*
3. Pregnancies
   - Total pregnancies in 203 cases 877
   - Total non-pregnant while using formula 170
   - Total pregnant while using formula. 33
   - Reason given for pregnancies
     - Admitted non-use 26
     - Admitted improper use 3
     - Unknown or failure 4
4. Effects reported, none.

The pregnancy rate in terms of 100 person-exposure years is 16.

TABLE II

Colored—Dade County, Florida

1. Cases
   - Number of cases at beginning of experiment, May, 1935 59
   - Total case histories as of June 1, 1937 850
   - Lost address, no report or other method 110
   - Total number of completed case histories 740
   - Cases eliminated, using formula less than 6 months 275
   - Total net cases reported on for this tabulation 465
2. Months used
   - Total number of months used to pregnancy 696
   - Total number of months used by 465 cases 6440*
3. Pregnancies
   - Total previous pregnancies in 465 cases 2303
   - Total number of pregnancies occurring while using formula..... 84
   - Pregnancies occurring in 1935..... 80
   - Pregnancies occurring in 1936..... 4**
   - Reasons given for pregnancies
     - Admitted non-use..... 79
     - Admitted improper use..... 0
     - Unknown or failure..... 5
4. Effects reported, none

The pregnancies occurring in these cases per 100 person-exposure years, for all pregnancies including admitted non-use, total 16.

If the pregnancy failures are computed per 100 person-exposure years, the rate becomes minus 1.

TABLE III

White—

Mothers Health Clinic of West Palm Beach

LouWilla Honacker, R. N., Supervising Director

1. Cases
   - Total cases beginning March, 1936, and ending September 1, 1937.... 177
   - Cases eliminated, using formula less than 6 months..... 34
   - Total net cases reported for this tabulation 143
2. Months used
   - Months used to pregnancy..... 106
   - Total months used all cases.....1674*
3. Pregnancies
   - Total pregnancies all cases..... 779
   - Total non-pregnant while using formula 126
   - Total pregnant while using formula. 17
   - Reasons given for pregnancy
     - Admitted non-use..... 9
     - Admitted improper use..... 1
     - Unknown or failure..... 7
4. Effects reported, none

*Number of months computed as of last date seen.

**This is taken to indicate a growing confidence in the method and better cooperation on the part of the patient.

Computed in terms of 100 person-exposure years, the pregnancy rate is 14.

Table IV

Tabulation of records taken by Helen Gould Countryman during November-December, 1936.

A cross section of Mothers Health Clinic cases of Miami using several foampowder formulas covering the period April, 1935,-December, 1936, inclusive.

Case Records	*White*	*Colored*	*Total*
Total number of case records	212	331	543
Cases eliminated using formula less than 6 months	108	80	188
Number net cases on which tabulation is made	104	251	355
Pregnancies			
Total number previous pregnancies	549	1311	1860
Cases not becoming pregnant while using formula	94	203	297
Cases becoming pregnant while using formula	10	48	58
Reasons given for pregnancy			
Admitted non-use	8	44	52
Admitted improper use	2	1	3
Unknown or failure	0	3	3
Months of Use			
No. of months used previous to pregnancy	91.5	384.5	476
Total number of months used formula	1066.5	3279.5	4345
Years of Marriage			
Total No. years married before using formula	1305.4	2738	4043.4
Total No. years married while using formula	7.6	32	39.6
Reported Effects of Formulas			
No. cases reporting no effects	96	233	329
No. cases reporting burning (discarded formulas)	8	18	26

Pregnancy rate 16, computed per 100 person-exposure years.

Conclusions

Contraceptive advice given to poor maternity risks is an inexpensive and quick method of reducing maternal mortality and more effective when combined with adequate prenatal and obstetrical care than either method alone.

Contraceptive information can be given to indigent sick families in their homes by trained case workers under the supervision of a physician.

Private clinics or those operated by private agencies cannot cope with the problem of providing contraceptive advice for the indigent sick of the population nor for those unable to employ private doctors.

Contraceptive advice scientifically applied may prove to be a useful adjunct to health departments in their program of reducing morbidity and mortality rates, especially for mothers and infants.

The cost of this method is but a fraction of trying to provide medical and hospital care for sick indigents. Wisely used it can prevent much needless suffering as well as eliminating many problems of community administration.

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3. Division of Vital Statistics, Florida State Board of Health.

4, 5. Voge, Cecil, I. B.: The Chemistry and Physics of Contraceptives. Jonathan Cape, London.

Carleton, H. M.: The Chemical Control of Conception. Chapman and Hall, Ltd., London.

6. Foampowder made by Carl Scheffel, Medical Director, Physicians Pharmaceutical Laboratory, Inc.

7. Technical Committee: A. Buist Litterer, Director of the Physicians Clinical Laboratory; H. W. Hamilton, Laboratory Technician; A. T. Knowles, Supt. of Veterinary Hospital; Carl Scheffel; Lydia Allen DeVilbiss, Director, Mothers Health Clinics.

8. O. K. Powell, M. D., Miami; A. Buist Litterer, M. D., Miami.

9. Carl Scheffel, M. D.; A. T. Knowles, D. V. M.

10. Stix, Regina K.; Notestein, Frank W.: Effectiveness of Birth Control, A Second Study, Milbank Memorial Fund Quart., April, 1935.

Florida Medical Association, Inc.

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HOSPITAL INSURANCE IN FLORIDA

It appears that hospital insurance is being promoted in a number of places in Florida by unauthorized companies. It has also been brought to the attention of the officers of the Association that new unauthorized companies are springing up over the state very rapidly at the present time.

A special representative of the Insurance Department of the State of Florida reported recently that he had run out of the state, or prevented from operating in the state, about forty unauthorized companies. As this Journal goes to press, it has been reported that only two companies authorized to sell hospital insurance are now in existence in Florida. The special representative of the Insurance Department also stated that, as he viewed the law, all contracts issued to date by hospitals are in violation of the state insurance laws. This so-called "hospital insurance racket" which seems to be spreading over the state, must eventually feel the hand of the law because of its irregularities. Those hospitals or organizations which are irregular will find drastic opposition.

The first insurance company recently authorized by the State Insurance Department has not only met the requirements of the Florida laws but, through its representative, has submitted its policy to the officers of the Medical Association for approval and is giving every indication of a spirit of cooperation in an effort not to infringe on the ethics of the medical profession.

As a preliminary step on the part of the officers, the President of the Florida Medical Association called together, informally, the officers of the Association, the chairmen of the Executive, Medical Economics, and Hospital Committees; a number of members of these committees; and representatives of the Florida Radiological Society. This group spent Sunday afternoon, October 3, studying the problem. The attorney who is a special representative of the State Commissioner of Insurance, and a representative of the first insurance company authorized to sell hospital insurance were invited to address the group. Considerable new light was thrown on the problem from different angles, which will undoubtedly be the means of definite action along constructive lines. The representative of the insurance company to which reference has been made, submitted his policy and stated that he had authority, without action of his Board, to change the policy. There appeared to be very few sections to which the medical profession would object. A special committee was appointed to recommend the changes necessary. Its report will be submitted to the Executive Committee at a called meeting in the near future.

The new companies springing up seem to have a tendency to follow the wording of the policy sold by the insurance company which is now qualified under the state law. It is, therefore, of paramount importance that this policy be standardized to meet the desires of the medical profession in the beginning. The wisdom of this procedure will be realized in a very definite manner in years to come.

It was a gracious move on the part of this insurance company to consult the medical profession in perfecting its policy and this is greatly appreciated by the officers of the Association. It is the will and obligation of the medical profession to use its organization for the protection of the sick and afflicted. The work of this particular phase of medical care is an opportunity to render a real service to the citizens of Florida.

NORTH CENTRAL DISTRICT

Ocala, centrally situated for a meeting of the North Central Medical District, calls you for an important case and urges you to be in attendance.

The host society, Marion County, was the first in the state to have all membership dues paid for 1937. The local committee, headed by Dr. T. H. Wallis, thus feels no hesitancy in calling all doctors in the district into consultation October 27.

A cordial invitation to get together and enjoy food for the physical and mental digestive apparatus is yours. Kindly let Doctor Wallis know if you'll come. The program speaks for itself; the food will be excellent the fellowship worthwhile. Coming, you'll be well paid; failing to come, you'll miss something good.

NORTH CENTRAL MEDICAL DISTRICT

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LOCAL COMMITTEE ON ARRANGEMENTS

T. H. WALLIS, *Chairman*
R. C. CUMMING
R. D. FERGUSON

HARRINGTON HALL HOTEL

Thursday, October 27, 1937

DINNER

P. M.
6:00—Dining Room

GENERAL SESSION

7:00—Call to Order—
A. B. ALBRITTON, *Senior Councilor*

7:10—Address of Welcome
RALPH E. RUSSELL, *President, Marion County Medical Society*

Brief Addresses by State Officers—

7:20—EDWARD JELKS, *President*

7:30—SHALER RICHARDSON, *Sec'y-Treas.-Editor*

7:40—W. McL. SHAW, *Chairman of Council*

7:50—Recognition of President-elect and Past Presidents
W. HENRY SPIERS, 1938
A. H. FREEMAN, 1911
L. M. ANDERSON, 1922
HENRY C. DOZIER, 1929
Other Past Presidents
Other Officials present

Selection of Meeting Place, 1938

Announcements

SCIENTIFIC SESSION

Presiding, R. B. HARKNESS, *Junior Councilor*

8:00—"Acute Conditions Within the Abdomen"
R. D. FERGUSON, Ocala

8:15—Discussion

8:30—"Some Experiences in the Diagnosis of Gastro-Intestinal Cancer"
EDWARD JELKS, Jacksonville

8:45—Discussion

9:00—"Complications Following Cauterization of the Cervix"
J. M. DELL, JR., Gainesville

9:15—Discussion

Adjournment

SOUTHWEST DISTRICT

The physicians of Plant City cordially extend an invitation to the Doctors and their wives of the Southwest Medical District of the Florida Medical Association to attend the First Annual Meeting at Plant City, Thursday, November 11, 1937 at 3 p. m. All members in this district may invite guest Doctors and their wives, provided they notify the Chairman of the Committee on Arrangements, Dr. B. H. Sanchez, Plant City. It is very important that the Entertainment Committee have a check on the number to be present.

The officers of the Florida Medical Association will be present at this meeting and you will, therefore, have an opportunity to meet them. The scientific program was arranged by the officers of the Hillsborough, Manatee, Pinellas, Sarasota, DeSoto-Hardee-Highlands, Lee, and Polk County Societies. The meeting place will be the City Hall Assembly Room.

Plant City is situated near the geographical center of the Southwest Medical District, accessible by state highways No. 23 and No. 17, as well as being located on both the Atlantic Coast Line and Seaboard Air Line trunk line railways. It may also be approached by Florida Motor Lines, Blue Bus Line, Greyhound Bus Line, and the Tamiami Trail Tours. This unique little city, filled with hospitable people who will extend you a warm welcome, is known as "The Home of the Country Gentleman" and "The World's Largest Winter Strawberry Center."

Your attendance is urged and we hope that you will come and mingle with the other Doctors of the Southwest Medical District. A sumptuous dinner will be served at the Hotel Plant that will be tempting to the palate of the most discriminate epicure.

SOUTHWEST MEDICAL DISTRICT

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LOCAL COMMITTEE ON ARRANGEMENTS

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J. C. KNIGHT
THOMAS C. MAGUIRE

SCIENTIFIC SESSION

Thursday, November 11, 1937
City Hall Assembly Room

P. M.
3:00—Call to Order—
J. A. Simmons, *Senior Councilor*

3:10—Address of Welcome—
George L. Cook, *President, Hillsborough County Medical Society*

3:20—"Appendicitis in Children"
D. D. Martin, *Tampa*

3:35—Discussion

3:50—"Quinine Amblyopia"
Shaler Richardson, *Jacksonville*

4:05—Discussion

4:20—"Disturbances of Thyroid Function"
Herman Watson, *Lakeland*

4:35—Discussion

GENERAL SESSION

Presiding, J. W. Alsobrook, *Junior Councilor*

Addresses by State Officers—
4:50—Edward Jelks, *President*
5:00—Shaler Richardson, *Sec'y-Treas.-Editor*
5:10—W. McL. Shaw, *Chairman of Council*
5:20—Recognition of President-elect and Past Presidents
W. Henry Spiers, 1938
W. P. Adamson, 1920
John C. Vinson, 1924
H. Mason Smith, 1926
John A. Simmons, 1927
William M. Rowlett, 1933
O. O. Feaster, 1936
Other Past Presidents
Other Officials present
Selection of Meeting Place, 1938
Announcements

DINNER

6:30—Plant Hotel

FLORIDA EAST COAST MEDICAL ASSOCIATION

The Tenth Annual Meeting of the Florida East Coast Medical Association will be held at Hollywood, November 12 and 13, with headquarters at the Hollywood Beach Hotel. The rate at this hotel will be $7.00 a day, American plan. This rate includes the banquet ticket Friday evening. An additional charge will be made for extra tickets for persons not paying the hotel rate.

This Association, in which membership is limited to physicians affiliated with the Florida Medical Association, covers the territory along the east coast from Key West to Fernandina; adjacent counties wherein there are no county organizations; Orange County; and Seminole County. Dr. E. B. Hardee of Vero Beach is president; Dr. Frederick J. Waas, Jacksonville, first vice-president; Dr. F. K. Herpel, W. Palm Beach, second vice-president; and Dr. Elbert McLaury of Hollywood is secretary of the organization. Dr. E. C. Swift of Jacksonville is chairman of the Scientific Program Committee.

The physicians and their wives of Hollywood, Ft. Lauderdale and vicinity, who will act as hosts, have made preparations which will assure an outstanding meeting. In addition to the excellent scientific program offered, fishing, golf, swimming and other forms of entertainment will add to the enjoyment of those who attend. Make your plans now to attend. Those who participated in the meeting of the Florida Medical Association several years ago at Hollywood need no introduction to this wonder spot of Florida.

PROGRAM

Friday, November 12
1:00 p.m.

Luncheon for Committees and Special Societies

SCIENTIFIC ASSEMBLY
2:30 p.m.

"Fractures of the Spine"
M. Paul Travers, Miami
Discussion:
F. A. Vogt, Miami
E. W. Cullipher, Miami

"Clinical Significance of Asthma in Heart Disease"
E. Sterling Nichol, Miami
Discussion:
W. W. George, West Palm Beach
Louie M. Limbaugh, Jacksonville

"Vaginal Approach to Stone in the Lower Ureter"
E. Clay Shaw and Jack A. McKenzie, Miami
Discussion:
James L. Estes, Tampa
Perry D. Melvin, Miami

"Some Observations on Hip Fractures"
Charles A. Mabry, Jacksonville
Discussion:
Arthur H. Weiland, Coral Gables

"The Diagnostic Value of the Neutralizing Function of the Stomach"
Kenneth Phillips and A. Buist Litterer, Miami
Discussion:
Elbert McLaury, Hollywood
Edwin C. Swift, Jacksonville

ENTERTAINMENT FOR VISITING LADIES
3:00 p. m.

BANQUET AND DANCE
8:00 p. m.

SCIENTIFIC ASSEMBLY
Saturday, November 13
9:30 a. m.

"Gonococcal Peritonitis of the Right Upper Quadrant"
T. F. Hahn, DeLand
Discussion:
E. B. Wood, Daytona Beach
S. Marion Salley, Miami

"Some Observations on Treatment with Sulfanilamide"
E. T. Sellers, Jacksonville
Discussion:
J. C. Nowling, West Palm Beach
H. D. Clark, Fort Pierce

"Protamine Insulin in the Treatment of Diabetes Mellitus"
Louie M. Limbaugh, Jacksonville
Discussion:
M. Jay Flipse, Miami
T. Z. Cason, Jacksonville

"Treatment of Poisonous Snake Bites"
A. D. Amerise, Coral Gables
Discussion:
J. C. Richardson, Miami
P. B. Welch, Miami

"Stricture of the Rectum in Lymphopathic Venereum"
Duncan McEwan, Orlando
Discussion:
A. L. Walters, Miami Beach
Edward Jelks, Jacksonville

ENTERTAINMENT FOR VISITING LADIES
10:00 a. m.

BUSINESS MEETING AND ELECTION OF OFFICERS
12:00 noon
Adjournment

GULF COAST CLINICAL SOCIETY

The Gulf Coast Clinical Society will hold its second annual meeting at Biloxi, Mississippi November 3 and 4, 1937. The Buena Vista Hotel will be headquarters, with all meetings taking place there.

This society was organized the early part of 1936 by the county medical societies in Gulfport, Biloxi, Mobile and Pensacola. Membership in this society includes physicians from Mississippi, southern Alabama, and northwest Florida. Doctor Herbert L. Bryans of Pensacola is first vice-president and Dr. M. A. Lischkoff of Pensacola is secretary-treasurer.

A special feature on Wednesday will be a clinic on "Borderline Mental Cases," to be held at the United States Veterans Hospital at Gulfport. For relaxation and good fellowship, there will be a fish fry and supper at Ship Island Wednesday evening. At a noon luncheon Thursday, from 12:30 to 2 o'clock, Dr. M. Edward Davis will conduct a round table discussion on "Cesarean Section." All doctors interested in this subject are cordially invited to attend.

The scientific program follows.

Scientific Program

1. "The Public Health and Control of Syphilis," R. A. Vonderlehr, Asst. Surg. Genl., U. S. Public Health Service, Washington, D. C.

2. "The Use and Abuse of Cesarean Section," M. Edward Davis, Asso. Prof. Obst. & Gyn., U. of Chicago, Chicago.

3. "Radiation Treatment of Cancer of the Breast," C. H. Heacock, Memphis, Tenn.

4. "Sterilization of Obstetrical Patients in Vanderbilt University Hospital from 1925 to 1937," Lucius E. Burch, Prof. Clin. Obst. & Gyn., Vanderbilt University, Nashville.

5. "How is the General Practitioner to Diagnose Food Idiosyncrasies," William C. Chaney, Asso. Prof. Med., University of Tennessee, College of Medicine, Memphis.

6. "The Therapeutic Value of the Intratracheal Use of Iodized Oil Combined with Eliminative Measures and Specific Desensitization in the Treatment of Intractable Asthma, Chronic Bronchitis and Bronchiectasis," Ray M. Balyeat, Asso. Prof. Med., University of Oklahoma, Oklahoma City.

7. "The Treatment of Malaria," Col. C. F. Craig, Prof. Tropical Med., Tulane University, New Orleans.

8. "Peripheral Vascular Disease," Alton Ochsner, Prof. Surg., Tulane University, New Orleans.

9. "The Mental Health Problem in Children," H. Casparis, Prof. Ped., Vanderbilt University, Nashville.

10. "Intractable Low Back Pain and Sciatic Pain Due to Protrusion of the Lumbar Intervertebral Discs: Diagnosis and Surgical Treatment," J. C. Love, Dept. Neurosurgery, Mayo Clinic, Rochester.

11. "Abdominal Injuries," Karl Meyer, Asso. Prof. of Surg., Northwestern University, Chicago.

12. "Venereal Diseases of the Ano-Rectum," Curtis Rosser, Prof. Proc., Baylor University, Dallas.

13. "On the Diagnosis of Gastro-intestinal Cancer," Edward Jelks, President, Florida Medical Association, Jacksonville.

14. "The Clinical Value and Limitations of Electrocardiography," E. S. Sledge, President, Alabama Medical Association, Mobile.

15. "The Economic and Social Side as it Appears to the Small Town and Country Physician," Joseph E. Green, President, Mississippi Medical Association, Laurel.

16. "Social Aspects of Medical Care," (to be presented at Banquet), Morris Fishbein, Editor, Journal of American Medical Association, Chicago.

STATE NEWS ITEMS

The Executive Committee of the Florida Medical Association, on recommendation of the Dade County Medical Society, has designated May 9, 10 and 11, 1938, as the official dates for the Sixty-fifth Annual Meeting of the Association. The meeting is to be held in Miami and the Columbus Hotel has been designated as headquarters.

* * *

Dr. James L. Estes of Tampa read a paper entitled "Unusual Urological Conditions" at the scientific session of the Georgia Urological Association, held in Macon, October 7.

* * *

Dr. John L. Anderson, in charge of hypoglycemic shock therapy at the Pilgrim State Hospital, Brentwood, New York, delivered an address at the Florida State Hospital on the evening of September 29. The lecture was attended by about 200 persons, including the staff, nurses, undergraduate nurses, supervisors and employees. The lecture was supplemented by moving pictures, showing the work being done at the Pilgrim State Hospital. Doctor Anderson served his internship at the Duval County Hospital a number of years ago, and is formerly of Cross City.

* * *

The names of the officers of the Florida Railway Surgeons' Association, who were elected at the April meeting in St. Petersburg, have just been received from the secretary: president, Dr. J. Ralston Wells of Daytona Beach; president-elect, Dr. Calvin D. Christ of Orlando; vice-president, Dr. A. R. Beyer of Tampa; secretary-treasurer, Dr. H. D. Clark of Fort Pierce; chairman of the Executive Committee, Dr. L. F. Carlton of Tampa; Chairman of the Scientific Committee, Dr. T. H. Bates of Lake City; and chairman of the Necrology Committee, Dr. F. J. Waas of Jacksonville.

* * *

Dr. O. O. Feaster of St. Petersburg was elected a member of the Executive Committee of the Radiological Society of North America, for a three-year term, at the annual meeting of the Society held in Chicago recently.

* * *

Dr. R. D. Thompson of Orlando, Superintendent of the State Sanatorium, attended the Mississippi Valley Conference on Tuberculosis held in Dayton, Ohio, the latter part of September.

* * *

The following Florida doctors were made Fellows of the American College of Radiology at its recent meeting in Chicago, held in connection with the Fifth International Congress of Radiology: H. O. Brown of Tampa, O. O. Feaster of St. Petersburg, F. K. Herpel of West Palm Beach, Gerard Raap of Miami, and W. McL. Shaw of Jacksonville.

* * *

Dr. William M. Rowlett of Tampa addressed the Chamber of Commerce of Goffstown, N. H., Wednesday, September 22. The subject of Doctor Rowlett's talk was "The Beauty of New Hampshire."

* * *

Among the Florida radiologists who attended the Fifth International Congress of Radiology in Chicago, September 13 to 17, were: Dr. E. M. Hendricks, Ft. Lauderdale; Drs. T. H. Lipscomb, H. B. McEuen and W. McL. Shaw, Jacksonville; Drs. A. G. Levin and Gerard Raap, Miami; Dr. F. J. Payton, Miami Beach; Dr. J. N. Moore, Ocala; Drs. J. A. Pines and W. A. Weed, Orlando; Drs. A. M. Bieker and O. O. Feaster, St. Petersburg; Drs. H. O. Brown and J. C. Dickinson, Tampa; and Dr. F. K. Herpel, West Palm Beach.

Dr. I. M. Hay of Melbourne, chairman of the Local Committee on Arrangements for the annual meeting of the South Central Medical District, attended the meeting at St. Augustine as an observer. Doctor Hay and his associates will, therefore, have some good pointers to guide them in entertaining the doctors from their own district. The Northeast District set a pace which will take work and ingenuity to surpass.

* * *

Dr. and Mrs. Thomas C. Kenaston of Cocoa announce the birth of a daughter, Marianne, on September 21, at St. Luke's Hospital, Jacksonville.

* * *

Dr. Maximilian Stern of Daytona Beach has returned from a three months' sojourn in the North, where he spent his vacation and also visited hospitals in various cities.

* * *

The Southeastern Branch Society of the American Urological Association will hold its fourth annual meeting in Birmingham, Ala., November 5 and 6. Headquarters will be at the Hotel Tutwiler.

* * *

Dr. Clayton E. Royce of Jacksonville recently received a certificate in pathologic anatomy and clinical pathology from the American Board of Pathology.

* * *

Dr. and Mrs. L. J. Netto of West Palm Beach returned early last month from a vacation spent in Nashville and middle Tennessee.

* * *

The annual meeting of the Southeastern Dermatological Association was held at Birmingham the weekend of September 4. Those from Florida in attendance were Drs. C. A. Andrews of Tampa and J. L. Kirby-Smith of Jacksonville.

The meeting was well attended by dermatologists from the principal cities of North Carolina, South Carolina, Georgia, Florida, Alabama and Tennessee. Charlotte, North Carolina was selected as the next meeting place. Officers elected for 1937-38 were: J. L. Kirby-Smith of Jacksonville, chairman; Cosby Swanson, Atlanta, vice-chairman; and Joe Elliott, Charlotte, North Carolina, secretary. The Southeastern Dermatological Association was organized in Jacksonville several years ago.

* * *

Dr. and Mrs. O. C. Brown of Ft. Lauderdale returned the latter part of September from a vacation trip through Wisconsin, Michigan, North Carolina, and Alabama.

* * *

Dr. Morris Fishbein will be guest speaker at a banquet to be held by the Escambia County Medical Society, Tuesday evening, November 2, at Pensacola.

* * *

Dr. R. W. S. Owen of St. Petersburg recently spent six weeks in Cleveland and Indianapolis, doing postgraduate work.

* * *

Dr. Gideon Timberlake of St. Petersburg spent six weeks in High Hampton, North Carolina, recently.

* * *

Dr. F. A. Gowdy announces the removal of his office to Fort Pierce. He formerly practiced in Miami.

* * *

Dr. Joseph Rose of Jacksonville announces the opening of offices at 611 Greenleaf Building for the practice of pediatrics.

* * *

Dr. Francis H. Langley of St. Petersburg spent his summer's vacation in North Carolina.

* * *

Dr. and Mrs. R. D. Ferguson of Ocala are the proud parents of a son, born September 1 in the Munroe Memorial Hospital. Two girls preceded this son but the young man seems to have the whole household well in hand.

* * *

Dr. Norval M. Marr of St. Petersburg, during the latter part of the summer, did postgraduate work in New York and Boston. He was absent six weeks.

* * *

Dr. L. L. Whiddon of Fort Pierce returned the middle of September from St. Louis, Mo., where he took postgraduate work in blood chemistry at the George Washington University.

* * *

Dr. R. H. Knowlton of St. Petersburg was a visitor in Boston recently and during his stay there, took postgraduate work.

Dr. C. E. Tumlin of Miami was a visitor in Jacksonville the latter part of September. He called at the headquarters office of the Association, as well as on a number of local physicians. Doctor Tumlin was on his way to Chicago, where he visited clinics. He spent some time in Asheville, North Carolina, and visited the Mayo clinic at Rochester.

* * *

Dr. W. M. Davis and family of St. Petersburg spent the months of August and September at their summer residence in West Virginia.

* * *

Dr. and Mrs. Paul K. Jenkins, accompanied by their children, Paul II, Ruth, Mary, and Sally, have returned to their Miami Beach home from a vacation spent at Harvey's Lodge and Boathouse on Lake Rabun, Lakemont, Ga.

* * *

The next examination (written and review of case histories) of the American Board of Obstetrics and Gynecology for Group B candidates will be held in various cities of the United States and Canada on Saturday, November 6, 1937, and Saturday, February 6, 1938. Application for admission to these examinations must be filed on an official application form in the office of the Secretary at least sixty days prior to these dates.

The general oral, clinical and pathological examinations for all candidates (Groups A and B) will be conducted by the entire Board, meeting in San Francisco, California, on June 13, and 14, 1938, immediately prior to the meeting of the American Medical Association.

Application for admission to Group A examinations must be on file in the Secretary's Office before April 1, 1938.

For further information and application blanks address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh, (6), Pa.

* * *

Dr. Leigh F. Robinson and family of Ft. Lauderdale returned recently from an extended vacation spent at Skyland, North Carolina.

* * *

Dr. R. L. Sullivay of Pensacola spent two weeks recently in Chicago, attending clinics at the Cook County Hospital.

Martha D. Hanson and Virgil Hanson daughter and son of Dr. Henry Hanson, former State Health Officer, who have spent fourteen months in Ecuador and Peru, South America, left Callao, Peru, August 10 on the British steamer, Laguna, for Balboa, Canal Zone, where they transferred to a Norwegian steamer, en route to Los Angeles, California to continue their studies. Martha entered as a student in the University of California at Los Angeles and Virgil took up his high school work in the same city.

* * *

Dr. R. L. Elliston of Ft. Lauderdale returned last month from the Mayo Clinic where he took postgraduate work.

* * *

Dr. and Mrs. Harold D. Van Schaick recently returned from a trip in the North. Mrs. Van Schaick was the guest of relatives on Long Island and Dr. Van Schaick visited clinics in Boston, New York, Cleveland, Chicago, St. Louis, and Rochester.

* * *

Dr. J. H. Rutter of Daytona Beach sailed for Europe on September 24 on the Baltimore Mail Liner, City of Hamburg, from Norfolk, Virginia.

* * *

The American Medical Association and the National Broadcasting Company present each week over the Red Network a program of dramatized health messages intended to furnish graphic supplementary material for health teaching in junior and senior high schools. Much of this material is also useful for elementary schools, especially in the higher grades. The topics of the broadcasts for the coming month are:

Oct. 27—Seeing and Hearing Well: hearing and vision; how to conserve these; how to recognize deviations; how to prevent loss.

Nov. 3—Striving for Better Bodies: so-called physical defects; their recognition; what can be done about them.

Nov. 10—Playing for Fun: health values and hazards in sports and recreation, including football.

Nov. 17—Fresh Air, Fresh Clothes and Fresh Skin: ventilation; clothing, bathing.

* * *

Dr. and Mrs. L. M. Gable of St. Petersburg are absent on a two months' tour of Europe.

ANNUAL MEETING NORTHEAST MEDICAL DISTRICT

The first annual meeting of the Northeast Medical District (C) was held at St. Augustine, September 23 at 3 p. m. The sessions were held at the club house on the golf links. The total registration was 104. Of this number, 62 were doctors who are members of the county societies in this district; 3 were visiting doctors from Orange County; 2 from Brevard County; 1 from Columbia County; 1 from Suwannee County; 2 from Leon County; 1 from Georgia; and 1 from Maryland. Eighteen were members and guests of the Woman's Auxiliary. Firms having headquarters in this district, who exhibited at the Association's annual meeting, received an invitation to have their representatives attend this meeting. Accepting this invitation were Mr. M. H. Weaver of the American Optical Company, Jacksonville, and Mr. Evans Folline, representing the Southeastern Optical Company, Jacksonville.

This is the third annual medical district meeting held so far this year and it was equal in success to the two previous meetings. The fact that so many doctors in a small district take advantage of the opportunity to get together on an occasion of this kind for good fellowship, renewing acquaintances, and becoming better acquainted with the men in their profession, is a definite indication that those responsible for promoting the annual meetings in the six medical districts of the state were farsighted and are making a real contribution to the doctors in organized medicine.

Dr. Charles C. Grace, President of the St. Johns County Medical Society, was absent on a hunting trip in Wyoming. Dr. Herbert E. White, therefore, served as chairman with Dr. R. D. Harris and Dr. Vernon A. Lockwood on the Local Committee on Arrangements. Doctor White is a very capable leader and under his guidance the members of the St. Johns County Medical Society acted as hosts on this occasion, distinguishing themselves by real hospitality. A barbecue cook was imported from Georgia and staged an old-fashioned Georgia barbecue which will long be remembered by those who were in attendance. Doctors who were not able to attend missed a real treat. The food was prepared and served on the lawn in front of the club house and the happy group, beautified by the presence of the many ladies, continued their feast into the dark hours of the night. Refreshments were served preceding the dinner and cigars and cigarettes were within reach at all times. All expense in connection with the occasion was defrayed by the members of the St. Johns County Medical Society. Doctors who had previously been entertained by this society rejoiced at the opportunity of again going to St. Augustine as guests of this outstanding group of doctors in the Ancient City.

The general session was held at 3:25 p. m. in the club house at the St. Augustine Golf Links. Dr. Hugh West, Senior Councilor, called the meeting to order. The address of welcome was given by Dr. Walter D. Webb. The presiding officer then called on Dr. Edward Jelks, President of the State Association, who was followed by Dr. W. Henry Spiers, President-elect; Dr. Shaler Richardson, Secretary-treasurer, and Editor of the Journal; and Dr. W. McL. Shaw, Chairman of the Council. Doctor West then called on the Chairman of the Executive Committee, Dr. Gilbert S. Osincup; the Chairman of the Public Relations Committee, Dr. J. Ralston Wells; a past president and life member of the Association, Dr. L. M. Anderson; past president, Dr. Frederick J. Waas; and Dr. George A. Davis of DeLand who has practiced in that city 43 years. Dr. Herbert White, Chairman of the Local Committee on Arrangements, then made the announcements concerning the activities of the evening.

The scientific session was opened by Dr. W. McL. Shaw, Junior Councilor, who presided. At 4:30 p. m. he called on Dr. Thomas M. Palmer of Jacksonville who read a paper on "Congenital Osseous Syphilis." The next paper was by Dr. Hugh West of DeLand on "Anomalies of Intestinal Rotation and Report of a Case." Both papers were interesting and instructive and held the attention of the entire audience from the start to finish. Under the supervision of Doctor Shaw, the daylight screen was operated by Mr. E. S. Hirsch, a representative of the Southeastern Optical Company. The question of the next meeting place was then taken up and Dr. Robert B. McIver extended, on behalf of the Duval County Medical Society, an invitation to meet next year at Ponte Vedra. The invitation

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was seconded by Dr. S. E. Driskell and accepted unanimously.

Registration

West, Hugh, *Senior Councilor*.....DeLand
Shaw, W. McL., *Junior Councilor*.....Jacksonville
Thompson, Stewart, *Managing Director*...Jacksonville

Members

Alford, Neil.....Jacksonville
Bell, F. Emory.....Palatka
Black, John B.....Jacksonville
Boone, James L.....Jacksonville
Brantley, Z.....Grandin
Britt, Reddin.....St. Augustine
Brooks, W. H.....Jacksonville
Brown, Alan.....Jacksonville
Cason, T. Z.....Jacksonville
Chowning, W. C.....New Smyrna Beach
Croft, Theodore G.....Jacksonville
Davis, George A.....DeLand
Driskell, S. E.....Jacksonville
Dyrenforth, L. Y.....Jacksonville
Ferrara, John D.....Jacksonville
Field, T. S.....Jacksonville
Gurganious, Allen.....Palatka
Hanson, Karl B.....Jacksonville
Harrell, O. E.....Jacksonville
Harris, R. D.....St. Augustine
Holloway, Luther W.....Jacksonville
Hughes, Victor A.....Jacksonville
Ira, Gordon H.....Jacksonville
Jelks, Edward.....Jacksonville
King, Raymond H.....Jacksonville
Kirby-Smith, J. L.....Jacksonville
Klein, L. A.....Live Oak
Limbaugh, Louie.....Jacksonville
Lipscomb, Thomas H.....Jacksonville
Lockwood, Vernon A.....St. Augustine
McCreary, A. B.....Jacksonville
McCullagh, W. H.....Jacksonville
McIver, Robert B.....Jacksonville
Mabry, Charles B.....Jacksonville
Manning, William S.....Jacksonville
Morris, Kenneth A.....Jacksonville
Myres, M. J.....Daytona Beach
Norris, S. R.....Jacksonville
Palmer, Thomas M.....Jacksonville
Peterson, C. A.....Jacksonville
Potter, G. W.....St. Augustine
Richards, Ferdinand.....Jacksonville
Richardson, George W.....Jacksonville
Richardson, Shaler.....Jacksonville
Rollins, C. D.....Jacksonville
Royce, Clayton E.....Jacksonville
Sanderson, Raymond.....Jacksonville
Sellers, E. T.....Jacksonville
Sompayrac, Lauren.....Jacksonville
Spencer, J. J.....St. Augustine
Stollenwerck, A. D.....Jacksonville
Swift, E. C.....Jacksonville
Teeter, E. H.....Jacksonville
Tyler, L. V.....Jacksonville
Veal, E. W.....So. Jacksonville
von Meysenbug, Ludo.....Daytona Beach
Waas, Frederick J.....Jacksonville
Walkup, A. C.....St, Augustine
Watt, E. C.....Jacksonville
Webb, Walter D.....St. Augustine
Wells, J. Ralston.....Daytona Beach
White, Herbert E.....St. Augustine

Guests from F. M. A.

Anderson, L. M.....Jacksonville
Hay, I. M.....Melbourne
Jewett, Eugene L.....Orlando
Kenaston, T. C.....Cocoa
Knight, C. M.....Palatka
Logie, A. J.....Jacksonville
Osincup, G. S.....Orlando
Spiers, W. Henry.....Orlando

(*Continued on page* 238)

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Gynecology — Diagnostic Courses; Clinical Courses; Special Courses starting every week.

Fractures and Traumatic Surgery—Informal Practical Course; Ten-Day Intensive Course starting October 11th.

Otolaryngology—Two Weeks Intensive Course starting April 4, 1938.

Ophthalmology—Two Weeks Intensive Course starting April 18th, 1938; Personal Course in Refraction.

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Visitors

Anthony, E. R. ..... Decatur, Ga.
Arnow, Matthew ..... Jacksonville
Brinkman, R. L. ..... Live Oak
Clements, M. R. ..... Jacksonville
Cox, Robert H. ..... Jacksonville
Fishbein, I. Leo ..... Jacksonville
Folline, Evans ..... Jacksonville
Hirsch, E. S. ..... Miami
Kemp, S. I. ..... Jacksonville
Moon, P. L. ..... Pierson
Morse, G. W. ..... Baltimore, Md.
Thack, A. B., Jr. ..... Jacksonville
Weaver, M. H. ..... Jacksonville

(Continued on page 244)

COMPONENT COUNTY SOCIETIES

DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The regular monthly meeting of the De-Soto-Hardee-Highlands County Medical Society was held in Wauchula, Tuesday, September 14. The following doctors were present: Drs. Weems, Kayton, Chandler, McKnight, Highsmith, McSwain, Martin, Peacock, Philpot, and Pease. Dr. James L. Estes of Tampa was a guest speaker and read a very interesting paper on "Symptoms, Diagnosis and Treatment of Prostatitis." Dr. Charles W. Pease of the State Board of Health discussed the question of establishing a venereal disease clinic and asked for an opinion of the members concerning the establishment of such a clinic. After considerable discussion, the society went on record as opposing the establishment of small clinics, in each town. The members of the society have agreed to cooperate with nurses and the State Board of Health by treating patients in their offices. The members of the society, therefore, felt that in this way, cooperation of the patient could be better established. There being no further business, the meeting adjourned.

* * *

DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society held its regular monthly meeting on Tuesday, October 5 at 8:15 p. m. in the State Board of Health Building. A symposium on "Complications in Obstetrics" comprised the scientific program and was presented as follows:

"Complications of the Prenatal Period"
S. R. NORRIS

"Complications of the Delivery"
A. D. STOLLENWERCK



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"Complications of the Puerperium"
T. S. FIELD

The discussion was led by Drs. Ferdinand Richards, J. M. Gorman and I. J. Strumpf.

* * *

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. W. Wardlaw Jones of Dade City acted as host to the Pasco-Hernando-Citrus County Medical Society at its meeting held Thursday evening, September 9. A splendid dinner was served at the Edwinola Hotel. The scientific program took place immediately after the dinner. After the reading and adoption of the minutes at the business meeting, Dr. H. L. Harrell of Lacoochee was elected an associate member of the society for the remainder of this year.

On motion, it was decided to hold the next meeting of the society on October 14 at Inverness, at the invitation of Dr. George A. Dame, senator from this district.

Those present were Drs. J. T. Bradshaw, Claude L. Carter, G. R. Creekmore, George A. Dame, H. L. Harrell, S. C. Harvard, W. Wardlaw Jones, R. D. Sistrunk, and W. Haywood Walters, Jr.

* * *

PINELLAS COUNTY MEDICAL SOCIETY

Dr. A. P. Roope of St. Petersburg was principal speaker at the meeting of the Pinellas County Medical Society held at the Shrine Club, on September 17. His subject was "Ambulatory Treatment of Hemorrhoids."

On October 1, the Pinellas County Medical Society held a business meeting at the Shrine Club, preceded by refreshments and dinner. During the meeting plaques were presented to past presidents of the society, as tokens of appreciation for service rendered the Society. The roster of past-presidents include: L. B. Dickerson, 1914; A. P. Albaugh, 1915; F. W. Wilcox (deceased), 1916; Harry Welch (deceased), 1917; R. H. Knowlton, 1918; A. J. Wood, 1919; W. M. Davis, 1920; J. D. Peabody, 1921; L. Lambdin, 1922; R. D. Murphy, 1923; O. M. Knox (deceased), 1924; C. A. Williams, 1925; T. R. Griffin, 1926; L. A. Wylie, 1927; H. L. Putnam (deceased), 1928; H. W. Wade, 1929; H. E. Winchester, 1930; R. K. O'Brien, 1931; O. O. Feaster, 1932; G. E. Miller, 1933; C. C. Rudolph, 1934; W. W. Harden, 1935; F. E. Kauffman, 1936; and N. M. Marr, 1937.

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TO THE

FLORIDA MEDICAL ASSOCIATION, INC.

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ESSAY PUBLICATION

The three prize winners of our essay contest on "The Problem of Ridding Florida of Tuberculosis" have already been published in the August *Journal* (page 110). The first prize essay, by Harriet Griffith of St. Petersburg, which was to have been published in our column, will be printed in the *Health Notes* of the Florida State Board of Health, where it will reach a larger lay audience.

I want to urge all of you to secure a copy of this, and see for yourselves one example of the splendid results which our contest produced. Miss Griffith's essay shows a wealth of information carefully collected, well organized, and set down in a straightforward style which will make it interesting to professional and lay groups alike. Those who helped sponsor this contest will find in the prize essay a rich reward for the tireless work which aroused in 10,000 Florida high school boys and girls an interest in our state's tuberculosis problem.

* * *

NATIONAL NEWS

It is with pleasure that we reprint, for the benefit of our Florida Auxiliary members, the officers and board of directors of the Woman's Auxiliary to the American Medical Association for 1937-1938, as published in the *News Letter,* September, 1937.

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* * *

IN MEMORIAM

The following tribute we publish in token of our deep regret at the death of Mrs. Edith R. McMurray, of Bartow, last August. She was the wife of the late Dr. E. R. McMurray, and was our leader in the year 1934-35 as President of the State Woman's Auxiliary.

Resolutions

In loving memory of Mrs. Edith R. McMurray:

"They call it death, when the angel comes
To open the door of life;
The door that opens and shuts us in
From the world's toil and strife:
When the boon of rest comes to weary souls,
When the burden of care is lost,
When the harbor of Heaven welcomes those
O'er the world's sea—tempest tossed—
Thank God for the door, whatever the name,
That awaits at the end of the road,
For it opens wide to let us in
To the Paradise of God."

WHEREAS, God in His wisdom, has summoned the sweet spirit of our sister and coworker, Edith R. McMurray, from her earthly home to her heavenly one; and

WHEREAS, We, the members of the Woman's Auxiliary to the Medical Association of Florida, are grateful to our Heavenly Father for her useful life with its benediction of precept and example that she so ably used as President of our Auxiliary; therefore be it

Resolved, That we bow in humble submission to the Divine decree that took her from our midst and the labor she loved, to a more perfect service above; that we cherish her memory and ever keep before us as most worthy of emulation the example of her faith, loyalty, and patience, and that we extend our heartfelt sympathy to the sorrowing daughter and son; and be it further

Resolved, That a copy of these resolutions be sent to the bereaved daughter and son, and also be inscribed on a page of our Minutes and Scrap Book, and that a copy be sent to the Florida Medical Journal for publication.

"So, when today becomes yesterday,
And you lie down to rest,
May we be able to truthfully say,
God doeth all things for the best."

MRS. JOHN F. WILSON, *Chairman*
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NORTHEAST MEDICAL DISTRICT

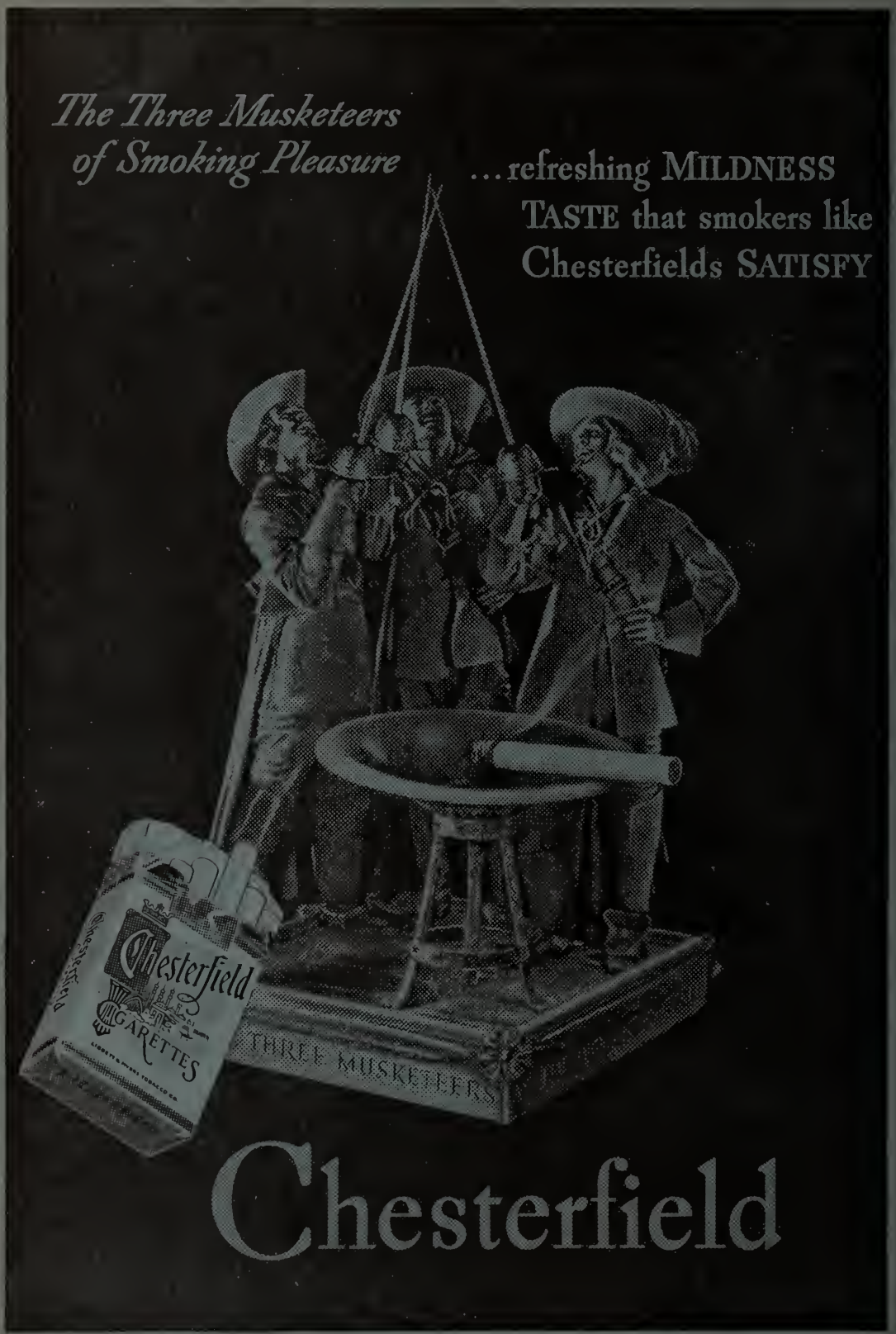
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COMPONENT SOCIETIES BY DISTRICTS—FLORIDA MEDICAL ASSOCIATION

Dis-trict	COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR *and Counties Not Included in First Column*	Members Total	Members Paid
N. E. District (A) Apalachicola, July 15, 1937	Bay	D. M. Adams, M. D., Panama City	Allen H. Miller, M. D., Millville	2nd Tuesday 8:00 P. M.	A-1-'38 John S. Turberville, M. D., Century	12	11
	Escambia	J. C. McSween, M. D., Pensacola	J. M. Hoffman, M. D., 1221 E. DeSoto St., Pensacola	3rd Thursday 8:00 P. M.		39	36
	Walton-Okaloosa	A. G. Williams, M. D., Lakewood	R. B. Spires, M. D., DeFuniak Springs			5	100%
	Washington-Holmes	G. W. Carter, M. D., Caryville	F. M. Watson, M. D., Chipley		*Santa Rosa*	7	6
	Jackson	C. H. Ryals, M. D., R.F.D. No. 1, Grand Ridge	Lewis Pierce, M. D., Marianna	2nd Tuesday 7:30 P. M.	A-2-'39 N. A. Baltzell, M. D., Marianna	15	12
	Leon-Gadsden-Liberty-Wakulla-Jefferson	L. L. Dozier, M. D., Tallahassee	B. A. Wilkinson,, M. D., Telephone Bldg., Tallahassee	Querterly 3:00 P. M.	*Calhoun-Franklin-Gulf*	37	35
N. Central District (B) Ocala, October 27, 1937	Columbia	T. H. Bates, M. D., Blanche Hotel Annex, Lake City	M. W. Spearman, M. D., Morrison Bldg., Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M. D., Lake City	12	100%
	Madison	E. Long, M. D., Madison	Geo. O. Davis, M. D., Madison			4	100%
	Taylor	G. H. Warren, M. D., Perry	J. C. Ellis, M. D., Perry	Last Friday 8:00 P. M.	*Baker-Dixie-Hamilton-Lafayette-Suwannee*	8	100%
	Alachua	T. A. Snow, M. D., 103 E. University Ave., Gainesville	H. M. Merchant, M. D., 124 E. University Ave., Gainesville	2nd Friday 7:30 P. M.	B-4-'38 A. B. Albritton, M. D., Wildwood	25	20
	Marion	Ralph E. Russell, M. D., Ocala	R. C. Cumming, M. D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P. M.		22	100%
	Pasco-Hernando-Citrus	W. Wardlaw Jones, M. D., Dade City	G. R. Creekmore, M. D., Brooksville	2nd Tbursday 7:00 P. M.		13	100%
	Sumter	A. B. Albritton, M. D., Wildwood	W. E. Mitchell, M. D., Bushnell	2nd Tuesdey	*Bradford-Gilchrist-Levy-Union*	4	100%
N. E. District (C) St. Augustine, Sept. 25, 1937	Duval	Kenneth A. Morris, M. D., 238 W. Church St. Jacksonville	George W. Croft, M. D., 713 Greenleaf Bldg., Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shew, M. D., Jacksonville	161	145
	St. Johns	Charles C. Grace, M. D., East Coast Hospital, St. Augustine	R. D. Harris, M. D., St. Augustine	3rd Tuesday 8:30 P. M.	*Clay-Nassau*	11	100%
	Putnam	H. A. Johnson, M. D., Palatka	F. Emory Bell, M. D., Palatka	2nd Tbursday 7:00 P. M.	C-6-'38 Hugh West, M. D., DeLand	10	100%
	Volusia	J. Ralston Wells, M. D., Woolworth Bldg., Daytona Beach	R. L. Miller, M. D., 258½ S. Beach St., Daytona Beach	2nd Tuesday 7:30 P. M.	*Flagler*	40	38
South West District (D) Plant City, November 11, 19[illegible]	Hillsborough	George L. Cook, M. D., 442 W. Lafayette Tampa	James S. Grable, M. D., 811 Citizens Bank Bldg., Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M. D., Plant City	102	98
	Manatee	Lowrie W. Blake, M. D., Bradenton	M. M. Harrison, M. D., Bradenton	3rd Tuesday 7:00 P. M.		12	100%
	Pinellas	N. M. Marr, M. D., 812 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D., 1005 Equitable Bldg., St. Petersburg	1st and 3rd Fridays 6:30 P. M.		87	86
	Sarasota	O. H. Cribbins, M. D., 224 Commercial Court, Sarasota	J. E. Harris, M. D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P. M.		18	16
	DeSoto-Hardee-Highlands	Gordon H. McSwain, M. D., Arcadia	L. W. Martin, M. D., Sebring	2nd Tuesday 8:00 P. M.	D-8-'38 J. A. Simmons, M. D., Arcadia	19	100%
	Lee	H. Quillian Jones, M. D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M. D., 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P. M.		13	100%
	Polk	R. E. Gilbert, M. D., 19 Postal Arcade, Winter Haven	J. R. Boulware, Jr., M. D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	*Charlotte-Collier-Glades-Hendry*	61	58
South Central District (C) Melbourne, Oct. 17, 1937	Brevard	W. C. Page, M. D., Cocoa	Bob Schlernitzauer, M. D., Rockledge	3rd Tuesday	E-9-'38 W. C. Page, M. D., Cocoa	10	5
	Lake	LeRoy H. Oetjen, M. D., Leesburg	W. L. Asbton, M. D., Umatilla	1st Tbursday 12:30 P. M.		17	16
	Orange	F. H. Harms, M. D. 64 No. Court St., Orlando	Hewitt Johnston, M. D., Box 2002 Orlando	3rd Wednesday 8:30 P. M.		63	62
	Seminole	H. D. Smith, M. D., Touchton Drug Bldg., Sanford	Douglas G. Scott, M. D., Box 489 Sanford	2nd Monday 7:00 P. M.	*Osceola*	13	100%
	St. Lucie-Okeechobee-Indian River-Martin	H. D. Clark, M. D., Bank & Trust Bldg. Ft. Pierce	Grover C. Hardie, M. D., 207½ Orange Ave. Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M. D., Ft. Pierce	14	100%
S. E. District (F) Miami, Sept. 3, 1937	Broward	George S. McClellan, M. D., Pompano	Oliver C. Brown, M. D., 915 Sweet Bldg., Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'38 F. K. Herpel, M. D., West Palm Beach	30	100%
	Palm Beach	Bailey B. Sory, Jr., M. D., Brazilian Court Hotel, Palm Beach	Lloyd J. Netto, M. D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P. M.		55	51
	Dade	R. N. Burch, M. D., 1774 S. W. Eighth St., Miami	Walter C. Jones, Jr., M. D., 802 Huntington Bldg., Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M. D., Miami Beach	262	246
	Monroe	Harry C. Galey, M. D., 532 Fleming St., Key West	W. R. Warren, M. D., 511 Eaton St., Key West	1st Sunday 9:00 P. M.		3	100%



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VOLUME XXIV
No. 5

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American Medical Association, San Francisco, June 13-17, 1938.
Southern Medical Association, New Orleans, November 30—December 3, 1937.

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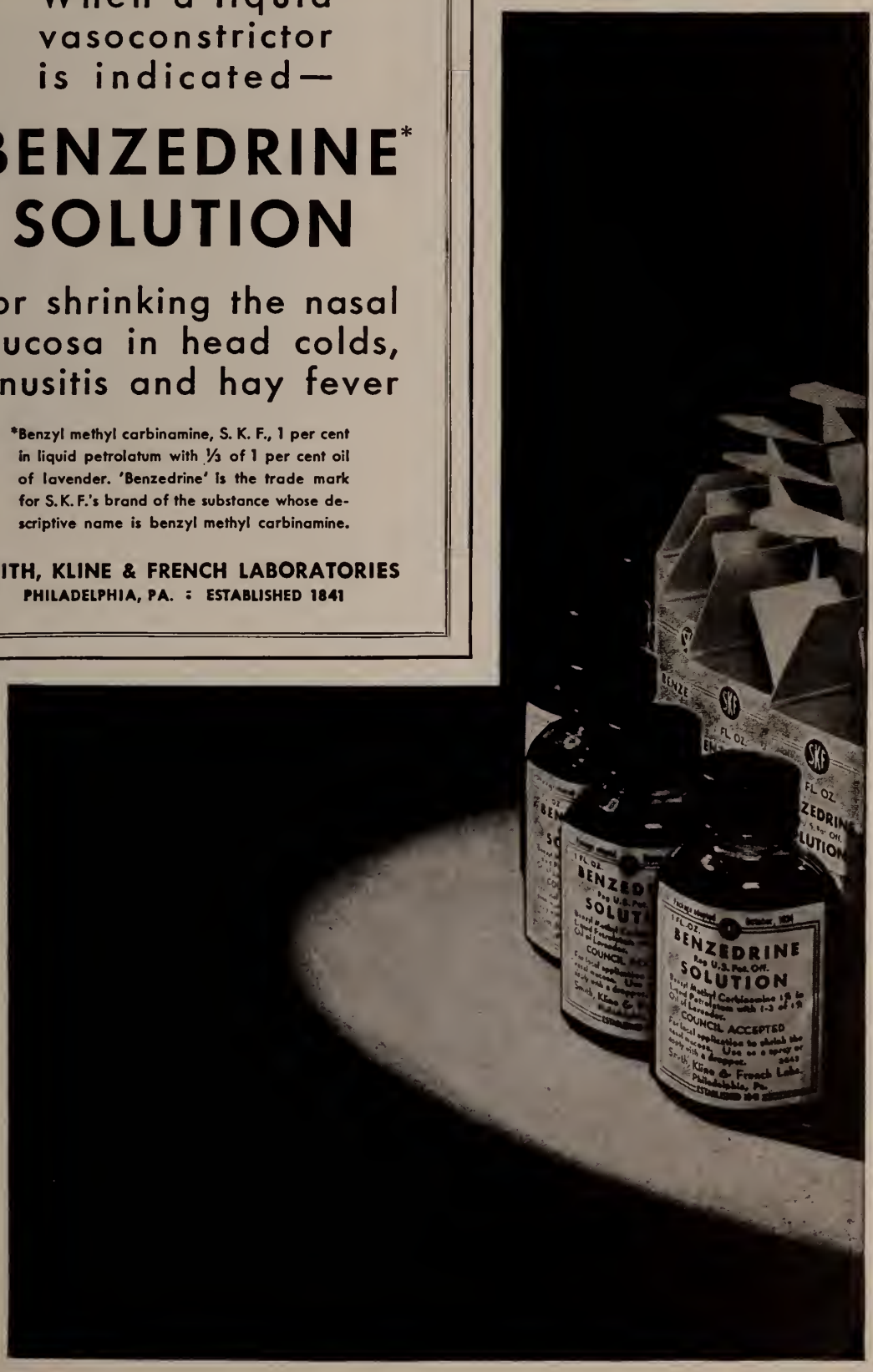
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(1) 1935. The Lancet 228-I, 71
(2) 1936. Am. J. Med. Sci., 191, 319
(3) 1935. Proc. Soc. Exper. Biol. & Med., 32, 1930
(4) 1933. J. Lab. & Clin. Med. 18, 484
(5) 1937. The Avitaminoses Eddy and Dahldorff William and Wilkins Baltimore
(6) 1936. J. Nutr. 12, 405
1936. Ibid. 11,383
1935. Am. J. Pub. Healtb 25, 1340

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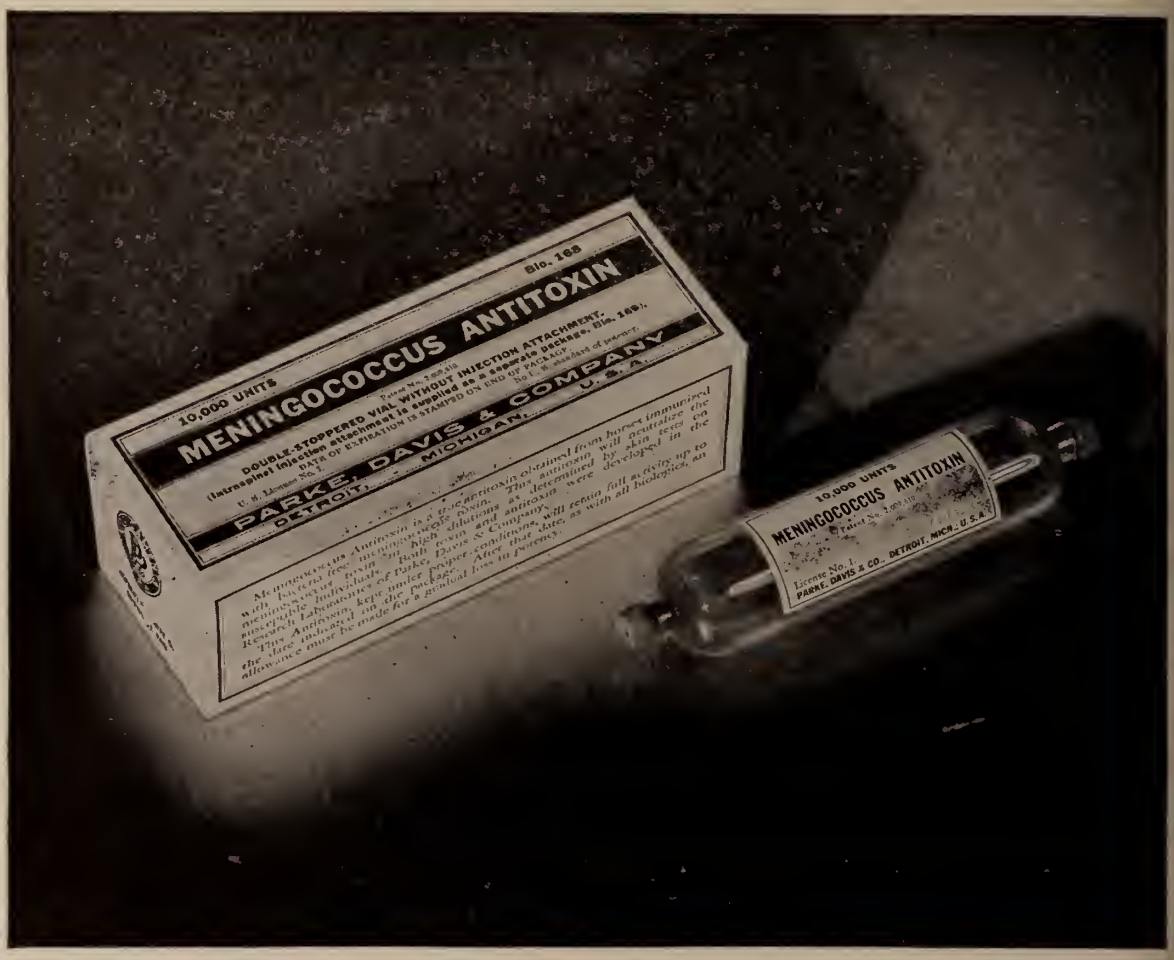
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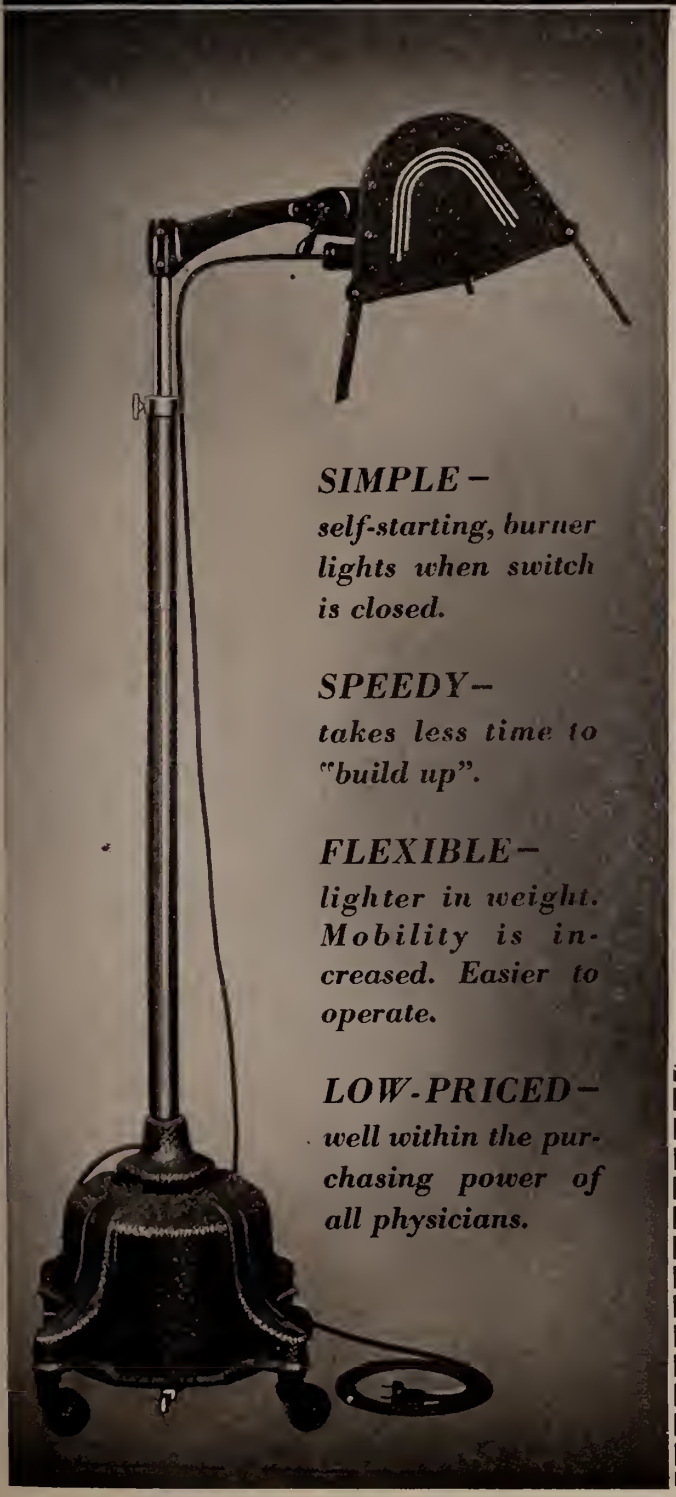
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In gastrointestinal disorders, "Dextri-maltose has been preferred to the other sugars as apparently less irritating."—*E. Cassie and U. Cox: The examination of the gastric contents in infants, with some considerations as to the value of lactic acid milk in infant feeding, Lancet, 2:322-325, August 14, 1926.*

"As to the kind of extra carbohydrate to be added, whether lactose or maltose, I believe dextri-maltose to be better in general in cases of fat indigestion (infantile atrophy)."—*C. H. Dunn: The Hygienic and Medical Treatment of Children, Southworth Co., Troy, New York, 1917, V. 1, p. 418.*

In the treatment of decomposition, "The period of repair may be shortened by giving suitable additional food; the best, probably, being buttermilk to which carefully regulated proportions of dextrin and maltose preparations or malt soup are added."—*E. Feer: Text-Book of Pediatrics, J. B. Lippincott Co., Phila., 1922, p. 284.*

In infantile atrophy, "The carbohydrate should be increased by gradual addition of dextrimaltose.

"Malt soup or dextrimaltose (Mead's) should be added in teaspoonful or more doses to each feeding until the point of carbohydrate tolerance is reached."—*L. Fischer: Diseases of Infancy and Childhood, F. A. Davis Co., Phila., 1925, V. 1, p. 285.*

In the case of a premature infant, "Dried milk with water was given, which later was changed to whole milk, 14 ounces; water, seven ounces, and dextri-maltose No. 1, one and one-half ounces. Seven feedings of three ounces each every three hours was given. The above feeding was retained. The infant gained eight ounces at the end of the first week."—*L. Fischer: Clinical notes in a series of premature infants, Arch. Pediat. 44:227-231, April, 1927.*

In the treatment of decomposition, "As a rule it is best to start with 2 to 2½ or 3 ounces of albumin milk to the pound weight in 24 hours; the sugar to be added is in the form of a maltose-dextrin mixture. One should never delay too long in adding this."—*C. G. Grulee: Infant Feeding, W. B. Saunders Co., Phila., 1922, p. 265.*

With reference to hypotrophy, "In mild cases, the addition of dextrimaltose instead of cane or milk sugar may be sufficient to obtain a gain in weight."—*C. Herrman: The treatment of nutritional disorders in artificially-fed infants, New York M. J. 114:158-160, August, 1921.*

In athrepsia, "The carbohydrates are usually added in a slowly fermentable form, such as the maltose and dextrin compounds, which are usually started by the addition of four grams per kilogram (1/15 ounce per pound) and increased until eight grams or more per kilogram (¼ ounce per pound) of body weight are added."—*J. H. Hess: Feeding and the Nutritional Disorders in Infancy and Childhood, F. A. Davis Co., Phila., 1928, p. 278.*

Concerning the treatment of marasmus, "When the stools have become smooth and salve-like, carbohydrate, in the form of dextrimaltose, may be gradually added up to the limit of tolerance."—*L. W. Hill: Practical Infant Feeding, W. B. Saunders Co., Phila., 1922, p. 281.*

In the feeding of prematures, "As soon as there is a hesitation in the gain in weight, dextrimaltose No. 1 is substituted for the dextrose, in the same amount in the mixture, with almost invariably a gain in weight."—*F. B. Jacobs: Relation of irradiated food substances and ergosterol versus cod liver oil in childhood nutrition, Pennsylvania M. J. 35:164-167, Dec., 1931.*

"A spasmophilic baby on bottle feeding should receive a limited amount of milk—a pint, or at the most 24 ounces in the 24 hours—to which cereal gruel and some form of sugar is added, preferably one of the malt dextrin preparations; also the early addition of other foods than milk to the baby's diet."—*M. Jampolis: Infantile spasmophilia, Interstate M. J. 25:652, Sept., 1918; abst. Arch. Pediat. 35:691, Nov., 1918.*

In cases of malnutrition and indigestion, "The appetite improves rapidly, and the stools soon become normal in appearance, if the sugars are intelligently prescribed. By this I refer to proper proportions of dextrin and maltose. When there is a tendency to looseness, I have used the preparation known as 'dextri-maltose,' for the extra carbohydrates; . . ."—*M. Ladd: Further experience with homogenized olive oil mixtures, Arch. Pediat., 33:501-512, July, 1916.*

In pyloric stenosis, "With low dextrose tolerance, a maltose dextrin preparation may be added in whole or in part. Even where the dextrose is well tolerated and gain in weight has ceased, impetus to the weight ontake may be given by the addition of a maltose dextrin preparation."—*D. J. Levy: Pyloric stenosis and pylorospasm of infancy with especial reference to medical treatment, J. Michigan St. M. S., 21:166-170, April, 1922.*

With reference to the treatment of diarrhea, "After several days, 2% to 3% of a maltose-dextrin preparation may be added (Dextri-Maltose). This is preferable to the easily fermentable lactose or cane sugar."—*F. Lust: The Treatment of Children's Diseases, J. B. Lippincott Co., Phila., 1930, p. 145.*

In dyspepsia, "The carbohydrate must not be allowed to exceed 3 per cent. Dextri-maltose is the most suitable sugar."

In the treatment of decomposition (atrophy, malnutrition, marasmus), ". . . when there has been obvious improvement, dextri-maltose is gradually increased from 3 to 5 per cent."—*B. Myers: The nutritional disturbances of infancy, Brit. M. J., 1:1079-1083, June 21, 1924.*

"The treatment of artificially fed children in the first of these groups consists in putting them on a low fat dietary, and giving them carbohydrate in the form of one of the less fermentable sugars—e.g., dextrimaltose."—*L. G. Parsons: Wasting disorders of early infancy, Lancet, 1:687-694, April 5, 1924.*

In the milder cases of inanition, "Regulation of this disturbed organismal balance is obtained by the addition of carbohydrates, while fat and casein are reduced. For this purpose dextrimaltose and flour are better than the ordinary sugars, since they are more slowly absorbed and have greater efficacy in their powers of controlling the flora in the large intestine."—*W. J. Pearson and W. G. Wyllie: Recent Advances in Diseases of Children, P. Blakiston's Son & Co., Phila., 1930, p. 116.*

In intestinal intoxication, "I have had more experience with dried skimmed milk in which 2 to 5 per cent dextrimaltose, barley or rice flour has been cooked, and the mixture subsequently fermented by lactic acid bacilli or soured with lactic acid, than with any other food except protein milk."—*G. F. Powers: A comprehensive plan of treatment for the so-called intestinal intoxication of infants, Am. J. Dis. Child., 32:232-257, August, 1926.*

Regarding the treatment of the marantic infant, "After the intolerance to sugar has been overcome a carbohydrate, preferably Dextri-maltose, may be added."—*C. S. Raue: Diseases of Children, Boericke & Tafel, Phila., 1922, p. 427.*

In spasmophilia, "Dextri maltose is the best sugar to use in these cases, in the proportion of 6 to 8 per cent."—*J. H. Reading, Jr.: Spasmophilia, Hahneman. Monthly, pp. 403-411, July, 1922.*

In the treatment of atrophy, "If the baby continues to improve, the next step in the treatment is to add to the milk one of the less fermentable carbohydrates, such as dextrimaltose; . . ."—*H. Thursfield and D. Paterson: Diseases of Children, William Wood & Co., 1929, p. 105.*

"I also find dextrin-maltose an excellent addition to albumin-milk when the first object of that food has been achieved and a gain in weight is desired; in this way I have succeeded in feeding albumin-milk far beyond the period usually advised, with highly gratifying results."—*F. L. Wachenheim: Infant-Feeding; Its Principles and Practice, Lea & Febiger, Phila., 1915, p. 158.*

"Dextri-maltose has been substituted for lactose not infrequently, when the tolerance for the latter continues low."—*I. H. West: Low fat, high starch evaporated milk feeding for the marasmic baby, Arch. Pediat. 48:189-193, March, 1931.*

"Malt sugar is indicated when others fail to produce a sufficient gain, or when malassimilation of fat is evident."—*O. H. Wilson: The role of carbohydrates in infant feeding, Southern M. J. 11:177, March, 1918; abst. Arch. Pediat. 35:447, July, 1918.*

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THE USE AND ABUSE OF X-RAYS IN THE TREATMENT OF SKIN DISEASES*

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Miami

The introduction of x-rays as a mode of therapy followed rapidly upon the announcement of their discovery by William Conrad Roentgen in 1895. Roentgenography began when he obtained a record of density outlining the bones of his hand on a photographic plate. Roentgen therapy followed with the observation of erythema and dermatitis which developed after long exposure to the rays. Schiff and Freund are credited with having first suggested their use in the treatment of disease.

With little or no knowledge of possible harmful effects, enthusiasm reigned. For a period of ten years attempts at treatment were made on a wide variety of conditions. The first efforts were directed toward the treatment of nevi, hypertrichosis, cancer and tuberculosis. Early improvement led to the wild hope that at last a cure was at hand for two of our greatest scourges. Both patient and operator suffered before caution was born. During these early years, practically every chronic disease was empirically treated. Some were over-treated, and others under-treated, while the medical press was swamped with unreliable literature.

The result of unrestrained enthusiasm proved to be discouragement and retardation in the development of x-ray therapy. Radiation therapy was early accepted by both European and American dermatologists, who were among the first to recognize its value and its limitations. Pusey and Stelwagon were American pioneers in the field of cutaneous roentgen therapy. The need for a method of measuring dosage was at once recognized, but the development of a practical ionization chamber was almost thirty years in the future. Not until Coolidge brought forth the electron tube in 1914, was roentgen therapy on a sound basis.

*Read before the Sixty-fourth Annual Meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, 1937.

The value and the limitations of x-ray therapy in skin disease is now quite well established. Reliable and accurate methods for the measurement of dosage are at hand. If only means could be devised to restrict the use of such a potentially dangerous therapeutic weapon to those qualified by training and experience, to use judgment and caution, serious accidents should be extremely rare.

However well grounded our clinical concepts may be for the use of radiation therapy in skin disease, there is still room for investigation into its biologic action. The precise manner in which x-rays bring about clinical improvement, particularly in infectious conditions, is not known. The bulk of all experimental evidence indicates, however, that it is not through the bacteriocidal or fungicidal action of x-rays. Very large doses are required to kill bacteria in artificial media, and positive cultures have been obtained in both bacterial and fungous diseases, days and weeks after fractional and intensive irradiation. Secondary rays produced in the tissues may exert bacteriocidal effects[1,2]. The most tenable theory is that the rays modify the soil in such a manner as to make it unsuitable for growth of the causal microorganisms. Whether this action is due to alteration of autolytic enzymes, or to some effect on the immune responses, is not known.

Rost[3] summarizes the action of x-rays on the inflamed skin as due to, (1) the action on local circulation; (2) necrobiotic action upon cells of the infiltration; (3) effect of the x-rays upon phagocytosis and (4) the action upon the reticuloendothelial system. This may lead to the liberation of endotoxins from the infiltrating cells.

In most conditions, in which x-ray therapy is particularly efficacious, its effects can best be explained by its inhibitory effect on karyokinesis in the young undifferentiated active cells. Conditions which respond best are characterized by multiplication of tissue cells, and over-activity of the secreting epithelium. The concensus of opinion is that the effect of irradiation on the malignant cell is due to inhibition of cell division.

Desjardins[4] rejects the idea that small doses of radiation are stimulating, and attributes any acceleration of cellular metabolism as an effort of the organism to counteract, or compensate, for the influence of noxious rays; in other words, as a defense mechanism. He also classifies cells according to their radio sensitivity. This is essential knowledge for anyone doing radiation therapy. Both lymphocytes and leukocytes are very sensitive to radiation, and respond to small doses. The testis contains, next to the salivary glands, the most sensitive epithelium in the body, and requires careful protection in radiation about the genitocrural region. The ovary is as sensitive but is more easily avoided in superficial therapy. If skin tolerance is exceeded, the first clinical sign will be a loss of hair in the exposed area. Slightly larger doses will produce a mild inflammatory response, and even a slight erythema may be followed in one to three years by telangiectasis. If severe enough, inhibition of sweat and sebaceous glands may be complete. Ulcers may form, which are slow to heal, and eventually carcinomatous degeneration may result. This latter complication is almost always the result of repeated doses rather than a single massive dose.

It is well, at this point, to state the aims of the dermatologist in using radiation therapy for the treatment of benign disorders. Briefly, it consists in using just that amount which will bring about a satisfactory clinical result, and no more. On the other hand, in the treatment of malignant conditions and in deep therapy, the aim is frequently to use the largest dose which the skin in the area exposed will tolerate. If the field is small, the quality of the radiation hard, and the dose divided, the skin will tolerate a much higher dose than is the case with superficial therapy.

To the dermatologist using unfiltered radiation, or 1 mm. of aluminum and 80 to 100 K. V., the skin erythema dose is equivalent to 300 to 400 r. units.[5] This produces, on the average skin, just an appreciable, or threshold, erythema. This is the erythema dose described by Mackee, and when a dermatologist refers to an erythema dose, he has this unit in mind. It should not be confused with Winz's H. E. D. (Hauterythem-dosis) which is about 600 r. and produces strong erythema, followed by pigmentation, which may last for months or years. Nor should it be confused with the "therapeutic erythema" used by radiologists, which may be 800 r., or with the newer epidermolytic dose of 1300 r. and more.[6]

Excluding malignancy, the problem of radiation therapy in skin diseases can briefly be divided into the treatment of acute and chronic conditions. The effects of irradiation therapy in the former is much harder to evaluate, since many of the conditions are self-limited, and are often treated simultaneously by other methods. Those who are too enthusiastic are likely to attribute results to irradiation therapy, which would follow in the natural course of the disease. In herpes zoster, relief of pain frequently follows irradiation over the corresponding dorsal root ganglion, and the involved area,[7] but the natural course of the disease is to spontaneous remission. In cases of long standing post-zoster pain, the results are not so brilliant. A statistical study on the duration of pain in treated and untreated cases, would establish the value.

Both furunculosis and erysipelas have been studied in this manner, and examination of these reports leaves little doubt as to the value of radiation therapy in their management. In both series, an equal number of treated cases is compared with those untreated, or not treated by irradiation. In the case of furunculosis,[8] Baeusch was able to show that the lesion was affected favorably 87 per cent of the time, either by decrease of pain, or a decrease in the time required for recovery. The mortality rate was also lower in the group treated by roentgen therapy. A conservative method of treatment, combining the use of x-rays with other methods, but avoiding radical surgery, has been described by Ayres, Anderson and Foster.[9]

In a similar study on erysipelas, Widmann[10] was able to show conclusively that the average duration of the disease was five days with radiation treatment, as compared to ten days with only routine medical care. Other acute conditions, such as ecthyma, cellulitis, paronychia and infectious eczematoid dermatitis, should be studied in a similar manner.

Turning now to chronic conditions, the problem of evaluation is different. Many of these disorders do not respond, or respond poorly, to other methods. The relation between treatment and effect is not so confusing.

The indications for treatment, and the choice of method, rest upon other factors. Before we start with radiation treatment, we must ask ourselves this question: Can I hope to cure the patient, or am I merely giving temporary relief from a chronic recurring condition? There are many chronic dermatoses which respond well to radiation therapy, possibly more quickly than to other methods, yet are not cured. The operator must be familiar with the natural history of the disease, and in such cases, give the smallest amount of treatment which will give satisfactory response. He must know when to stop, and he must warn the patient against excessive x-ray treatment. The shopping patient, with an intractable pruritis, chronic eczema, or inveterate psoriasis, is not a rarity. He is willing to risk his skin, and your reputation, for quick and easy relief.

There is probably no other condition in which roentgen therapy is more widely used than in the treatment of acne vulgaris. Not every case, however, is suitable for this method of attack. Better and more permanent results ensue if the treatment is withheld until the age of seventeen, or later. This is a good rule to follow, exceptions being made only where the process is severe enough to cause scarring. In mild cases, the response to radiation therapy is not so brilliant, and local treatment is more appropriate. It is, of course, a therapeutic sin to neglect supportive and corrective measures which are clearly indicated, and to rely solely on one method. The safest and most widely used plan of treatment is that of weekly quarter erythema doses. The maximum safe dose is sixteen such weekly treatments, and it is but seldom necessary to approach such tolerance. Only experience, and response of the patient's skin, can be used as guides to terminate treatment.

In selecting cases for treatment, it is important to exclude industrial and drug forms of acne. Permanent cures, in as high as 60 per cent of patients treated, and at least temporary improvement in possibly 30 per cent more, can be obtained. Relapses should not exceed 15 per cent.[2] Erythema of the mildest degree may be followed by telangiectasis, and should be avoided at all costs. If treatment is too long continued, wrinkling and dryness of a permanent nature may ensue.

The treatment of fungus infections by this method needs more careful scrutiny. Ringworm of the scalp can be rather summarily disposed of, insofar as Florida is concerned. It is common knowledge, among dermatologists, that tinea tonsorans, in certain sections of the country, will respond to local measures alone, if the treatment is carefully and persistently carried out. Lewis,[11] in a recent paper, has summarized the subject. The type of invading organism determines the necessity for epilation and, fortunately, the type common in Florida is a microsporid of the ectothrix type which will respond to local treatment and is apparently even a self-limited disease at times. Since ringworm of the scalp disappears spontaneously at the age of puberty, one is obviously not warranted in using epilating doses in this age group.

In considering the treatment of so-called "athlete's foot," and similar eruptions on the hands, the problem of diagnosis is paramount. If the condition is a true fungus infection, it will almost invariably respond satisfactorily to appropriate local measures. While it is true that absolute eradication of the fungus infection is rarely obtained and relapses, at least over long intervals, are common, it has not been my experience that x-ray therapy adds anything to the end result. Excellent symptomatic response is, however, frequently obtained. Infection of the toe nails is common[12] and its eradication, short of removal of the nail, almost impossible. Even removal does not guarantee against recurrence from the nail bed. Many vesicular eruptions of the hands and feet, which are so frequently treated as fungus infections, do not actually contain fungous elements and are frequently misdiagnosed[13,14] Some respond beautifully to irradiation, at least when it is first initiated, but relapse frequently; others respond poorly, or not at all.[15].

The therapy of warts is always good for a discussion as it can frequently be highly unsatisfactory. In plantar warts which are painful, and in verrucae occurring about the fingernails, x-ray therapy, if successful, is a most gratifying form of treatment. From 750 r. to 1200 r. is administered to the lesion, which is closely shielded. It is a mistake to repeat the treatment in less than six weeks, or oftener than once. Permanent cure by this method

can be expected in 50 per cent of patients treated. If successful, much pain and a disfiguring scar can be avoided. For warts in other locations, radiation is infrequently the method of election.

In circumscribed neurodermatitis with localized patches of lichenification, which are frequently seen at the nape of the neck and in the flexors, brilliant initial results are almost invariably obtained. The relief from itching is prompt. Relapses, however, are frequent and consequently one is not justified in giving large doses or pushing treatment to tolerance.

Results in disseminated neurodermatitis (atopic dermatitis) are much more uncertain and are frequently disappointing in children. There is, however, the outside chance that the result will be satisfactory and permanent. If due care is used, a trial is worth while. Symptomatic relief usually compensates one for the effort.

The status of x-ray therapy in pruritis ani is much the same. It is inexcusable to rely on radiation therapy until all local and systemic causes of pruritis about the ano genital region have been investigated and corrected, if possible. Many unsatisfactory results can be avoided in this manner as radiation treatments can scarcely be expected to cure diabetes, rectal fistula, pin-worms, or hemorrhoids.

Irradiation is not the method of election in the treatment of psoriasis and, when used at all, should be under the direction of one who is thoroughly familiar with the natural history of the disease. It may refuse to respond, get worse, or clear up spontaneously, during a course of treatment. For the most part, I prefer to use other methods, reserving x-ray treatment for intertrigenous lesions which cannot be adequately treated by local applications. It can be used for the occasional chronic patch occurring on exposed parts in a patient who cannot carry out the local treatment and possibly for elderly patients whose life expectancy is less likely to lead them into overtreatment by this method.

Radiation therapy has had its most brilliant results in the field of cutaneous malignancy. Even in the treatment of skin cancer, there is much room for a choice of method as between excision, destruction, roentgen treatment and radium therapy. Location, size and the type of lesion, as well as the time factor, expense involved, and equipment at hand, will dictate the type of treatment. Any method which completely destroys, or removes, the lesion will result in a cure if metastasis has not occurred. I prefer not to use irradiation on the average small non-infiltrating epithelioma if located on a senile atrophic skin; on those immediately over-lying bone or cartilage; or when gross infection is present. For similar reasons, I do not feel that senile keratoses and seborrheic verrucae are best treated by irradiation. Many radiation therapeutists have obtained excellent results under just such conditions.

X-ray therapy still stands condemned as a method of treating hypertrichosis although there is an occasional report of apparent success.[16] The financial possibilities are too alluring for certain commercial interests, however, and one still sees an occasional case of late roentgen dermatitis which has resulted from such attempts. Because of the undesirable results, epilation of the beard, in the treatment of sycosis, is to be avoided and used only as a method of last resort.

In conclusion, I wish to point out that there are many cutaneous diseases in which roentgen therapy is of no value, and that there are a few conditions in which it seems to be contraindicated. A correct diagnosis, and a knowledge of the natural course and prognosis of the disorder, are the first prerequisites for intelligent treatment. Undesirable sequelae from superficial therapy are usually the result of technical errors in administration of treatment, or to a lack of caution in its application.

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DISCUSSION

Dr. J. Lee Kirby-Smith, Jacksonville:

Dr. Sams' able presentation today of the use and abuse of x-ray in the treatment of skin diseases should be read carefully by all of the profession, particularly the roentgenologists. It is a very timely subject to be discussed. Prefacing my remarks with a statement of facts, in a private practice of twenty-six years in Jacksonville in the matter of the treatment of skin diseases, I have treated with x-ray 6500 patients, giving to them approximately 42,000 treatments, and during all these years I have never had a complaint from a patient regarding overtreatment with x-ray.

I would like to divide the therapeutical facts of x-rays on the skin into two classes: first, the carefully given fractional units for ordinary dermatoses; and, second, the intensive measure for the destruction of epitheliomas. In the matter of the first, Dr. Sams did not emphasize the most important consideration, i.e., the physiological action of the x-rays on the gland structures of the skin, and in my opinion this is the basis of its therapeutics. Both the sebaceous and the sudorific glands are particularly affected by carefully given fractional units of x-ray, given weekly. Retarding their functions and directly lessening both objective and subjective symptoms of the skin disease by this method of treatment, we have a valuable agent to control many of the common skin conditions met, as acne vulgaris, seborrhoids, acute eczema, dysidrotic conditions as fungus infections of the sudorific glands that we now designate as dermatophytosis.

In the second consideration, epitheliomas, Dr. Sams did not call your attention to the fact that it has been ascertained, after many years of experience, that the ordinary type of skin cancer or epithelioma will break down or disintegrate with so many definitely given units of x-ray at one dosage. However, exceeding a certain dose the normal healthy skin will be destroyed with resulting ulcer which we designate as an x-ray ulcer. With experience and proper care this should not happen.

Returning to the first subject, fractional x-ray treatments to ordinary dermatoses, I cannot close my remarks without emphasis on certain important factors. Treatment should not be given for skin diseases without a knowledge of the cause and course of the disease. Records should be carefully kept. Treatment should not be repeated oftener than once a week and under no circumstances should the total of the weekly treatments exceed the amount that we know as a skin unit during one month's time. The effect of even fractional doses of x-ray are accumulative. Treatment given this year will have a direct bearing on treatment given the next. This is mentioned particularly, as it is a known fact that patients favorably affected by an x-ray treatment will go from one doctor to another asking for treatment, and under no circumstances should he receive one without inquiry being made as to those previously given. This would obviate the many badly damaged individuals with whom we often come in contact. I would like to mention that today, as in the past, we have in south Georgia and Florida to my certain knowledge, operators of x-ray machines who are the source of many badly treated patients. Hardly a month passes that I do not observe the marks of excessive x-ray treatment for ordinary dermatoses.

I have recently had patients who have told me they have had treatment by chiropractors and dentists. To cite an instance of improper treatment, a few weeks ago I had an individual in my office with a very uncomfortable dermatitis of the lips. He had been referred to the x-ray technician in the hospital for the treatment of keratosis of the lower lip (cancer?). Instead of shielding with lead, both

lips were exposed for a fractional unit repeated five times in ten days. Of course the lip recovered from the immediate discomfort. With our experience we realize the danger of future trouble for this patient.

In closing my remarks I would say with emphasis, x-ray treatments are the most valuable means that we dermatologists have for the treatment of skin diseases. Given with accuracy and care it is absolutely safe. A moderate hypodermic injection of morphine would answer a purpose, but by carelessness and ignorance an excessive dose would mean danger. An appendix or gall bladder properly removed by a competent surgeon is a safe and proper procedure, but done by one without training or facilities, it is prone to be dangerous.

Dr. Frazier J. Payton, Miami Beach:

I wish to compliment the essayist on his thoroughness and thoughtful conservatism; also to emphasize and elaborate slightly on certain points he has made.

He expressed a wish that the use of radiation might be in some way reserved to those qualified to use it. Its continued indiscriminate use is probably entirely the cause of the present high insurance rates to those who employ radiation in treatment. It is also responsible for the ill repute it bears in certain localities.

I wish to emphasize that even a mild erythema may be followed in one to three years by telangiectasis. It is questionable if the larger doses now employed by radiologists do any more to the skin, if as much, after the recovery period because of the smaller relative absorption of soft rays in the superficial layers and about cutaneous blood vessels.

Let me also emphasize by repetition that Ayers, Anderson and Foster state that in a general collective experience, the recovery time for carbuncles and furuncles is halved by conservative means, i.e., x-ray and supportive treatment and that there is a lower mortality rate for such lesions in the more serious locations.

The observation that x-ray in the treatment of fungus infections is of no value is at least interesting. I should like to hear more discussion on this point. I am sure Dr. Sams meant that it had no effect on the fungus itself but on the inflammatory reactions and secondary infection usually present.

There may be differences of opinion about treatment of superficial malignancies. Many radiologists will prefer x-ray or radium in the same cases in which the essayist eschews them. Probably, it resolves itself into the skill with which the given modality is used, except that for x-ray and radium, high filtration is essential if bone and cartilage are to receive little injury. In Doctor Sams' hands undoubtedly cauterization of these lesions is the method of choice for I am sure they are and will be well long before any radiation reaction has subsided.

Dr. Elmo D. French, Miami:

I am in accord with Dr. Sams in his lack of overenthusiasm for the use of the roentgen rays in the local treatment of skin disease. In superficial or fractional exposures or destructive intensive exposures, one should rarely use this modality exclusively. By its combined use with other measures it is often possible to secure a more sure result with a less intensive x-ray treatment, and this is to be desired. One may, for example, activate an old long standing keloid by use of electrolysis or carbon dioxide snow and cause subsequent involution with a dose of x-ray otherwise without effect.

There is another point which might be emphasized. Roentgen ray sequelae are unsightly and especially about the orifices as the lips, constantly subject to irritation with discomfort, and even subject to grave malignant degeneration. Over treatment of benign lesions or of so-called precancerous lesions by massive doses of x-ray is rightfully condemned.

Dr. L. B. Mount, St. Petersburg:

I am taking the liberty of personally congratulating Doctor Sams on this most conservative paper. It does one a great deal of good to listen to an essay marked by such conservatism. I have been able to contrast this with perhaps the first complete report made on the use of x-rays in dermatology given by Sterns, a roentgenologist at Mt. Sinai Hospital in New York City in 1907. In his article, Sterns must have taken an index of dermatology because practically every condition was reported upon as being amenable to the use of x-rays and that was in the days of the old gas tube.

I also want to agree with Doctor Sams that the x-ray is a dangerous weapon and, as he

has stated, it should be in the hands of those only who are versed in its use and who know exactly what they are treating. He has stated that there should not be over 15 per cent relapses in the treatment of acne. I have followed the use of x-rays in dermatology from the days of the gas tube. It is a fine statement to read that the relapses should not be more than 15 per cent but one very difficult to parallel in my own experience. Perhaps I am not as well versed in the use of the rays as others are. I have found that a very large proportion of these cases of acne which are reported upon as cured in the strict sense of the word, when they are followed long enough, are found to have recurrences. If the treatment is pushed far enough to cure, an atrophy of the sebaceous glands and skin ensues, which creates a terrible looking skin. I am sure that ultimately the essayist will feel about the same as I do now.

I think, as the years go by, that I make use of the rays less and less. They, in my hands, are narrowing themselves down in usefulness to exactly those conditions which I feel can be cured by them and by them alone.

Dr. Wiley M. Sams, Miami, (Concluding): I wish to thank those who have discussed my paper. There are one or two points which I wish to emphasize. In the discussions of fungous infections of the hands and feet I stated that x-ray treatment adds nothing to the end result, my contention being that the infection is seldom eradicated by this method. However, involution of the eruption is frequently hastened and the speed of involution is usually in direct proportion to the degree of the inflammatory reaction. It is of little benefit in the treatment of non-inflammatory fungous lesions. The present tendency to consider all vesicular eruptions of the hands and feet as mycotic in origin is unfortunate. There was a time when they were classified as dyshidrosis or vesicular eczema; this was followed by a cycle six or eight years ago in which they were considered as preponderantly fungous infections or an allergic reaction to the presence of mycotic organisms. The pendulum is now swinging in the opposite direction.

On the question of malignancy, I think we all agree that the type of lesion and its severity as well as the location must be considered in selecting treatment. It is for the small, non-infiltrating epitheliomas, which are frequently not larger than a split pea, that I recommend destructive treatment in preference to radiation therapy.

I am very pleased to have Dr. Mount comment on my paper, particularly on the introduction and early use of x-rays in the treatment of skin diseases. My figure of 15 per cent relapses following x-ray treatment of acne is taken from Dr. MacKee's text book but my percentage may be higher.

HYPOTHYROIDISM*

Norval M. Marr, M. D.,
St. Petersburg.

The earliest description of thyroid deficiency was given by Curling in 1850, who described the clinical features of two children in whom no thyroid tissue was found at autopsy, but interest in this condition was aroused by Fagge in 1871. The latter stated that the wasting of the thyroid body was the probable cause of cretinism. To Ord is given the credit of the term, myxedema. In 1890, Horsley suggested the implantation of thyroid substances for the correction of myxedema, and Murray conceived the idea of making an extract of sheep's thyroids for subcutaneous injection. In 1891, the first patient was treated in this manner. To Fox and MacKenzie is given the credit for the oral administration of thyroid extract.

Interest in thyroid deficiencies has been limited to myxedema and cretinism until recent years. With the arrival of the basal metabolism, clinicians became conscious of thyroid deficiencies without myxedema and thus was coined the term hypothyroidism, or hypothyrosis, and some speak of this condition of hypothyroidism with or without myxedema. The classroom and textbook picture of myxedema is so clear to us that we will not discuss it here, but limit ourselves to hypothyroidism without myxedema, or hypothyrosis.

As in all thyroid disorders, males are less affected than females. Many authorities claim that in order to make a diagnosis of hypothyroidism, we must have the clinical picture, lowered metabolic rate and improvement through the use of thyroid medication. A

*Read before the Annual Meeting of Florida Midland Medical Society, Plant City, Oct. 27, 1936.

further laboratory aid is the blood cholesterol, which is elevated. The signs and symptoms which form the clinical picture are many and varied, such as dry and thickened skin, slow pulse, dryness and thinning of the hair, constipation, gastro-intestinal disturbances, fat pads, narrowing of the palpebral fissures, emotional instability, depression, fatigue, insomnia, pallor, anemia, sensitiveness to cold, muscular and rheumatoid pains, headaches, amenorrhea, menorrhagia or metrorrhagia, sterility, retarded healing of skin lesions, dermatological conditions, disturbance of conduction mechanism to the extent that complete heart block may result. It is often said that obesity is due to lowered metabolism, but seldom is this the case. We know of hypothyroidism cases in which the patients were underweight and gained weight when a normal metabolic rate was established. Hypothyroid heart disease has been described by various authorities, in which there is an enlargement of the heart, an electrocardiograph with a low voltage, T wave changes and conductions disorders. I recall a patient of mine about five years ago, decompensated and with a marked edema, who had an electrocardiograph similar to the above. She failed to improve on the usual treatment and mercurial diuretics were of no use. I regret to say that my suspicion of a hypothyroid heart was not aroused until after her death. I believe that we will hear more of hypothyroidism in the future, and I am going to be so bold as to say that failure of the usual therapeutic measures plus mercurial diuretics should rouse one's suspicion of a hypothyroid heart. The older clinicians appreciate the diuretic effect of thyroid medication.

The advent of the basal metabolism apparatus was responsible for the differentiation of hypothyroidism with and without myxedema, and today it is considered essential equipment in most hospitals and in many physicians' offices. However, we must be conscious of the fact that not all lowered metabolic rates are to be interpreted as due to hypothyroidism. Even when the metabolism reading is made under most ideal conditions, we must remember that it is a laboratory procedure and, as such, is subject to errors. In a climate such as Florida's, I believe that the normal range is between -10 and -15, and it is not unusual to have failures in cases which are below -15. Failure of patients to respond to thyroid therapy is perhaps due to not ruling out such endocrine disorders as hypo-ovarianism, hypopituitarism, or hyposuprarenalism. Where the clinical picture does not fit in with the lowered metabolic rate, a blood cholestrol estimation may serve as a check. Sometimes we see the asthenic type with a lowered metabolism and they may fail to respond to thyroid therapy. It is possible that the lowered metabolism is a compensatory state for some unknown reason. Examples of this are seen in diabetes and some of the blood dyscrasias. The method of treatment varies, but I have felt that any standard thyroid extract given orally will attain the desired results. It is well to remember that it takes about six to eight weeks for a patient to become conscious of any material benefit. Care should be exercised to see that the patient isn't getting too much thyroid and developing the signs of hyperthyroidism. Personally, I like to keep my patients on the minus side of the metabolic scale. The physician should become familiar with one of the standard thyroid preparations and not use different preparations on different patients, because this invites confusion. I prefer to begin with small doses and gradually increase the dosage, being governed by the patient's condition. This is probably due to the fact that most of my patients are elderly. If the patient has coronary artery disease, I do not use thyroid extract, because by raising the metabolism the coronary system may be further embarassed.

The following are a few of what I prefer to call the atypical hypothyroid cases. Some of these patients were under my observation for quite some time before I became aware that the lowered metabolism was the etiological factor in their malady. By my mistakes, I hope you will profit.

Mrs. M.—age 48.—Married. No pregnancies. Onset of menopause at age 40. From 1930 to 1933 I attended her on various occasions for attacks of numbness of entire left side, at which time there was always an elevation in blood pressure—reaching 230 systolic at one time. Between attacks the principal complaint was fatigue. I considered her case as vascular in origin. A basal metabolic rate of -36 was obtained in 1933, and since the maintaining of a normal metabolic rate she has had no attacks as described above and her fatigue has disappeared.

Mr. B.—age 41.—Married. Seen in 1932. A native of New York state, he was sent to Florida on account of nervousness, insomnia, and loss of weight. This had extended over a period of two years. The only thing on examination which suggested a thyroid deficiency, was a pulse of 66 per minute. Basal metabolic rate was found to be -25. After the establishment of a normal metabolic rate his nervousness and insomnia disappeared and he regained his normal weight. He returned to his former occupation, that of an executive, and has continued in good health ever since, his controlling dose of thyroid extract being one grain a day.

Mrs. C.—age 62.—Married. Three normal pregnancies. Weight, 98 pounds. A native of Pennsylvania. First seen in 1932, she complained of weakness, shortness of breath, diarrhea, and sore mouth. Blood studies revealed a pernicious anemia. After eight months on what was believed to be adequate liver therapy, her blood picture, diarrhea and sore mouth disappeared, but her low metabolic rate of -30 remained about the same. We then began the use of thyroid extract and after establishing a normal metabolic rate, the fatigue and shortness of breath disappeared. By the continued use of liver and thyroid, she has maintained a good state of health. There has been no material gain in weight. Her controlling dose of thyroid is one-half grain a day.

Mrs. L.—age 52.—Married. One normal pregnancy. Weight 180 pounds. Menopause began at 45. She was first examined in January, 1931, when her chief complaint was "itching and thirst." It was found that she had diabetes with a blood sugar of 500 mgs. per 100 cc. of blood—24 hour specimen contained 4% sugar with acetone and diacetic acid. No loss of weight. Pulse 68 per minute. Her skin was dry, but this was thought to be due to the diabetes. She was placed on the usual diabetic regime and her minimum amount of insulin was found to be twenty units a day. In November, 1932, she developed pains in both knees and back. Reviewing her case and considering that she had a slow pulse, a dry skin—the texture of which had not improved by a satisfactory diabetic regime—and a history of no loss of weight previous to the diagnosis of diabetes, we did a basal metabolism, which was found to be -40. After establishing a normal metabolic rate, the pulse rose to 80 to 90 per minute, the rheumatoid-like pains disappeared, the texture of the skin became normal. Insulin was discontinued in April, 1933, and since this time she has maintained a normal carbohydrate tolerance. Her weight since the above date has varied from 165 to 176 pounds. I believe that this patient's diabetes was secondary to her thyroid dysfunction. Her maintenance dose of thyroid is one grain a day.

Mrs. A.—age 52.—Married. History of two normal pregnancies. Weight 90 pounds, height 5 ft. 2 in. Home in New York state. First seen in January, 1935. Menopause began two years previous to this. For the past twelve years she had complained of fatigue and during this time she had had various therapeutic measures tried on her. There was nothing in her physical examination to suggest thyroid deficiency and I must confess that my only excuse for doing a basal metabolism was that practically everything else had been done. Two readings on two different days gave a -46. She was given thyroid extract and a normal metabolic rate established in about three months. After being on the thyroid for eight weeks, she began to improve. She returned to her home after spending the winter months in Florida, and when seen about eight months later stated that the fatigue had entirely disappeared and that she had gained 16 pounds in weight. Her controlling does is one-half grain a day.

Conclusion:

As a result of the cases of hypothyroidism which it has been my privilege to study and observe, I have come to the following conclusions:

1. That hypothyroidism without myxedema is much more prevalent than hypothyroidism with myxedema.
2. That the clinical picture is so variable that many of these atypical cases go undiagnosed.
3. That hypothyroidism is seldom the cause of obesity.
4. That the controlling dose of thyroid extract varies considerably, and in my experience most of those having a very low basal metabolic rate required the smaller doses.
5. That the diagnosis of hypothyroidism without myxedema depends more on the basal metabolic rate than on the clinical picture.

EARLY PREGNANCIES — OBSERVATIONS ON VAGUE ABDOMINAL PAINS*

W. WARDLAW JONES, M. D.
Dade City

We do not find so much written on this subject in literature, but there are a number of references made to it in articles relating to other topics.

In questioning female patients closely we can obtain admission that they have about midway between menstrual periods some uneasy sensations in one or both lower abdominal quadrants. These may or may not be associated with constipation or increased frequency of micturition. This type of discomfort we now believe comes as the result of the expulsion of the ovum from the ovary. These have no relation to pregnancies. Menstruation cramps are also not considered.

Garrison in his classic on *The History of Medicine* tells us in his discussion of early Greek medicine that at times there were those patients with "bad pains in the lower stomach which later delivered children at full term." These no doubt were some of the same type of cases we are seeing today. Analyzing further, we find these cases can be grouped into three large classes.

The first class includes those females which history reveals have not had previous abdominal pains and especially the pelvic type of pain. When the uterus begins to enlarge in the case of early pregnancy it assumes roughly a jug shape. This, in many individuals, will allow a retrodisplacement of the fundus and a subsequent pulling sensation in the region of the internal inguinal rings on one or both sides. Those persons who have the misfortune of possessing the underdeveloped or infantile type of pelvic organs seem to be the most likely candidates for this type of pain. Backache is a frequent complaint. Clinically speaking, these types of discomfort are the same as that experienced with retroversions without the pregnancies complicating them. Keeping this patient off her feet as much as possible, using hot vaginal douches, and using the knee-chest posture for five or more minutes, three or four times a day, apparently are about as good therapy as we can offer at this time.

There are few more distressing and disappointing things to the physician than something like this: we see a patient who complains of some vague abdominal discomfort, whom we find to be menstruating freely, whose uterus is about double the normal size and slightly softer than normal, and whose cervix is also soft and questionably open. In our talk with the patient and family we assure them that a mishap must have taken place. About seven months later we are called upon to deliver this patient of a fine full term child. We then seem to be in a position of not being able to explain our mistake. When we first see this type of patient, rest, knee-chest postures, simple bromides, combined with the injection of some of the anterior pituitary-like sex hormones seem to aid in checking these bleedings. This type of history is usually found in those individuals who have irregular and occasional profuse menses, and who seem prone to have the time between periods shorter than the four-week average. Frequently we find such cases of pregnancy following hypertrophic endometritis when several months prior it was necessary to do a dilatation and curettage in order to control hemorrhage. It is a habit of many folks, and especially those of the rural communities, to find out that they are pregnant and to consult their physician the next time during labor. This is one of the reasons for the high maternal and fetal mortalities. It seems that education is going to be the only solution for that type of case.

The early pregnant patient, without previous history of pelvic pains, may complain of pains in the sides of her abdomen. She is usually a rather nervous type of person, cannot definitely tell you where pain is located, perhaps has a full sensation in the rectal area, or maybe a slight elevation of temperature, but has no bladder symptoms. All you are able to demonstrate is tenderness in one or both lower quadrants over the pelvis, that the uterus is hard to outline, and the fornices are tender. The first thought is a mild case of pelvic inflammatory disease, even though mention is not made of that diagnosis to the patient, inasmuch as there is not yet enough evidence for a certain diagnosis. Palliative

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treatments and time clarify the situation, however.

It has been my good fortune to have observed several cases giving histories that were essentially similar to the following: patient about 42 years of age with menses irregular now, when previously they were regular. She does not worry as to pregnancy, having had several, the youngest child being 10 years old; a previous abdominal operation with some perineal repair. She complains now of a new type of pain in her lower abdomen which frequently is referred toward the vagina. On examination is found an enlarged pregnant uterus. The only explanation I can offer for these pains is that they are due to stretching of structures previously made tight at the operation.

The next great class includes those whom we may be certain have had an acute pelvic inflammation in the past. A patient will return to us saying that in the last few days she has started feeling worse than she had been and wonders if the old trouble is recurring. The examination reveals an active leukorrheal discharge, rarely a positive gonococcal smear, and that the tubes and the ovaries are tender, in addition to which the uterus seems to be rather tender and slightly enlarged. Immediately we think that her old condition has flared up and that it not only has reappeared but that it has become active in the uterus as well. This type presents difficulties for frequently the condition goes on a few weeks and a miscarriage takes place in spite of the fact that our treatment was of the ultra-conservative type. We feel more at ease when we are on the conservative side of things, having advised rest, perhaps some warm vaginal applications, proteins or other similar therapy that could have done nothing to harm the patient.

Closely allied with this type of case is the one which has a past history of gonococcal infection of the pelvic structures. There is noted at this examination no evidence of infection; the patient has practically no leukorrheal discharge, no special points of tenderness, yet she complains of pain in the general region of her ovaries. Doctor Hunner, writing in one of the chapters of Dean Lewis' "Practice of Surgery," says that he believes they receive these pains from adhesions between the fimbriated ends of the fallopian tubes and the ovaries being put on a stretch. This seems to be a plausible explanation.

I have mentioned therapy, only in a passing way. The vast majority of these patients will take good care of themselves if we will let them, by not doing anything too radical. The less we do the better, and if things are done, do only those things which will in no way harm the patient. Rest helps a great deal. Use the simple sedatives of the bromide class. Advise against any form of sexual excitement. Avoid all jolts and jars and, in particular, long automobile rides. Do not be in haste to operate, for your case of so-called pus tubes and endometritis may turn out to be a case of pregnancy. Glandular therapy helps in some instances.

This paper is presented not for any new scientific facts brought out in it, but in order to stimulate interest, which will lead to more accurate diagnoses and the consideration of cases of vague abdominal cramps, which might be due to pregnancies and not to infections.

PHYSICAL EXAMINATIONS IN RAILWAY MEDICINE*

Vernon A. Lockwood, M. D.
St. Augustine

Every railway surgeon knows how to examine applicants for employment, and in general what disabilities call for the rejection of defective applicants, but often he has never received an explanation as to the reason why certain physical disqualifications are a bar to employment.

It should be constantly borne in mind that the employer wants men who can work with safety to themselves and others; who are physically qualified to do their work; who will not burden the hospital association; and who have an employment expectancy that justifies their participation in a pension fund.

When examining an applicant for employment, a railway surgeon should look ahead twenty years. The man with the compensated heart murmur, able to perform heavy work today, will break down with ten years of laborious effort, be placed on the pension roll,

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and will spend much of his time in an orthopneic state in the hospital before he dies. Better for the individual himself that he had been advised as to the nature of the ailment and that he had obtained a less strenuous position elsewhere.

We must be constantly on the alert for those diseases which are apt to recur, placing a burden upon our hospital association and the pension fund. Arthritis and pulmonary tuberculosis belong in this category and a history of a previous attack may be considered a case for rejection. Diabetes is another disease that is costly to treat whenever insulin has to be supplied over a number of years.

The premature loss of a valued employee from physical disability deserves consideration in our farsighted policy. For example, a promising young man with a history of previous pulmonary disease is taken into our Freight Traffic Department and is given several years' training regarding freight rates and other data pertaining to freight solicitation. As a solicitor, he forms invaluable contacts with shippers. Should he become disabled by a recurrence of the old affection, a new man cannot step into his shoes and hold all of the business that has been solicited. This situation is quite comparable to the efforts of a younger practitioner, endeavoring to hold the practice of an established physician who becomes disabled by illness.

Safety is, of course, the prime requisite in the selection of a candidate for employment. It is hardly necessary to mention that an engineer must have good vision and hearing, a safe level of blood pressure, and a good heart. Not all applicants need to pass as rigid an examination, in this respect, as train service employees.

Certain physical defects that might become aggravated by trauma, thereby increasing compensation for the injury or favoring a damage suit, disqualify. Arthritic conditions of the spine and hernia come under this classification. It is easy for an injured person to claim an aggravation of a pre-existing disability, even though this condition has not been made worse by the recent injury. A moral if not a legal obligation exists, should an employee, blind in one eye, become blinded through accident.

Although our rules disbar an applicant with hernia, exceptions are occasionally made in cases of older employees undergoing reexamination, where a release is signed and a truss worn. This waiver usually discourages the employee sustaining an aggravation from presenting a claim. Ordinarily, a ruptured man is safeguarded and benefited by operation, and physical examination rules fulfill a good purpose by bringing this about.

While we endeavor to encourage the eradication of venereal disease by allowing afflicted employees to remain at work, we do not add to the number of cases within the organization by accepting applicants so infected. Industrial surgeons have demonstrated the fallacy of laying off these employees as these diseases are present in the plant at all times, relatively few cases being discovered unless a sympathetic attitude prevails. It is safer, from standpoint of dissemination of infection among fellow employees, to teach hygienic measures to the majority of affected employees, who will report in confidence, than to make an example of an occasional case that might accidently be brought to light.

It is unfortunate that age may make employment difficult, yet employers, who by reason of voluntary contributions to a pension fund, cannot be expected to employ those who will be eligible for pension within a few years, before they have actually earned the right, by length of service, to participate. Lessened productiveness with advancing age and a greater likelihood of burdening hospital associations on account of the degenerative diseases that come in later life, are added reasons for the imposition of an age limit.

All of us dislike, as physicians, to reject an applicant for employment. Our peace of mind, it seems to me, must come through the adoption of a philosophy that physical, as well as mental assets, should be considered in the selection of candidates for employment and promotion.

Some local surgeons will occasionally accept a physically defective applicant for employment for various reasons. The defect may be overlooked. The examiner may serve the applicant in the capacity of family doctor. Most of us dislike to keep anyone from securing employment, particularly in these days.

To remedy these faults and to give the local surgeon an excuse for adhering strictly to examination rules, we have instituted a check-up examination, performed at the hospital, where laboratory and x-ray facilities are available. Only those employees remaining in permanent service receive this final examination and within a period of three months from the time of the local surgeon's preliminary examination. Urine and blood tests and fluoroscopy of the chest is done in each case. Other laboratory and x-ray work is performed if indicated. Visual and aural examinations of all train service employees are performed by a specialist. We have found this additional examination to be efficient and worthwhile.

It is hardly necessary to point out the fact that people are benefited by physical examinations, regardless of the source through which the doctor is contacted. The detection of incipient tuberculosis, and early malignancy, or diabetes may be a lifesaving measure. The institution of treatment in cases of latent syphilis may prevent the serious cardiovascular or neurological lesions that crop out late in the disease process. Even the negative examinations have a reassuring effect upon the individual.

The physician benefits from his opportunity to do physical examinations, whether his connection be industrial or insurance. He establishes contact with people who are prospective patients. He has an opportunity to impress the employee by his friendly manner, thorough and conscientious professional work, and by his alertness he may detect for the first time some remediable disease such as syphilis, diabetes, or hernia, the patient often selecting the examiner as his physician. The taking of Kahn tests, and the making of urine and stool examinations, always pay big dividends in the practice of medicine.

For these reasons, we can state that physical examinations benefit the employee, employer, and physician. The painstaking, conscientious railway surgeon will protect the public as well as the railway by the selection of safe employees to operate trains. He will safeguard the employee by the detection of incipient disease, and will increase his own practice by making the most of contacts that might not otherwise be formed



Southern Medical Association Meeting

The Thirty-first Annual Meeting of the Southern Medical Association will be held at New Orleans, November 30 to December 3, inclusive. All members of the Florida Medical Association are invited and urged to attend this meeting. Of particular interest to the profession in the South are these annual meetings where clinical sessions, eighteen sections, and an expanse of scientific and technical exhibits constitute a four-day education in the later developments of scientific medicine. This meeting in New Orleans will be one well chosen for the specialist and general practitioner alike. The program will afford keen interest to both in the wide variety of meetings and exhibits, all housed under one roof at the municipal auditorium. (See colored insert for further particulars).

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FEDERAL CONTROL OF CANNABIS

The federal "Marihuana Act" became effective October 1, 1937. Regulations for effectuating the provisions of the act were approved September 29 by the Secretary of the Treasury. So many inquiries have been received by our office from Florida physicians that it seems wise to reproduce the following explanation which was prepared by the Bureau of Legal Medicine and Legislation of the American Medical Association:

FEDERAL CANNABIS REGULATIONS APPROVED*

The general requirements of the act as they relate to physicians were stated in the Organization Section of the A. M. A. Journal, September 11, pp. 31B and 32B. Every physician who distributes, dispenses, gives away, administers or prescribes cannabis or any of its derivatives or preparations is required by the act to register with the collector of internal revenue of his collection district, obtain an official registration number and pay the required tax.

Applications for registration must be filed on form 678c, procurable from the collector of internal revenue. An inventory, in duplicate and under oath, of all cannabis and preparations thereof on hand must be filed with the application. Physicians will normally register in class 4 and be subject to a tax of $1 each year. A physician who sells or dispenses cannabis apart from the legitimate practice of his profession is liable to an additional tax of $3 a year as a dealer. If he dispenses cannabis only incidentally to the legitimate practice of his profession, he incurs no liability for the tax imposed on the dealer. A physician maintaining an office in a collection district where he is duly registered with the collector of internal revenue and where his stock of cannabis and his cannabis records are kept may, but only in the course of his professional practice, distribute, dispense, give away, administer or prescribe cannabis in other collection districts in which he lawfully engages in the practice of his profession, without incurring additional tax liability; but if he maintains an office in another collection district or even maintains two or more offices in the same collection district, he must pay a tax with respect to each office.

Hospitals, colleges, medical and dental clinics, sanatoriums and other institutions, not exempt as government institutions, are subject to the same taxes and incidental regulation as other registrants similarly dealing in or handling cannabis. When an institution is subject to tax, the head thereof or of the department wherein the cannabis is to be used must sign the application for registration. Nurses, under the regulations, are regarded as agents of the practitioners or institutions under whose direction or supervision their duties are performed. They are not permitted to register under the act nor are they permitted to be in possession of cannabis except as such agents, or as patients. Cannabis left by a physician with a nurse, to be administered during his absence, must on her discharge from the case be returned to the physician, who will account for it on his records. Any cannabis found in the possession of a nurse not at the time under the supervision of a physician will be forfeited to the government.

A physician desiring to obtain cannabis must make application on form 679a (Marihuana), to the collector of internal revenue for the district in which the physician is located for the purchase of an order form. The application must show (1) the physician's name, address and cannabis registry number,

*J.A.M.A., October 16, 1937, volume 109, number 16, pp. 63B and 64B.

(2) the name and address of the person from whom the cannabis is to be purchased, and (3) a description of the desired cannabis and the amount to be purchased. The application must be accompanied by a certified check, cash or money order in payment of the transfer tax of $1 an ounce or fraction thereof, plus 2 cents in payment of the order form. Order forms will be prepared by the collector in triplicate. The original and duplicate will be delivered to the physician. He will deliver the original to the person from whom he purchases the cannabis and preserve his duplicate copy for two years. The triplicate will be retained by the collector. There are no exempt medicinal cannabis preparations; every preparation containing cannabis in any form and in any amount is covered by the act. Physicians must keep daily records showing the kind and quantity of cannabis dispensed or administered, the name and address of each person to whom dispensed or administered, the name and address of the person on whose authority the cannabis was dispensed or administered, and the purpose for which it was dispensed or administered. Every such record must be kept for a period of two years in such manner as to be readily accessible to inspection by investigating officers. No special record form will be furnished by the government for the use of those registered as practitioners, including hospitals and institutions, but each registrant is advised to keep records in the manner that is best calculated to enable an inspecting officer quickly to ascertain the quantity and kind of cannabis used daily. The initials of the practictioner giving directions for the administering of cannabis to a patient in a hospital should appear on the patient's record chart, or a prescription may be used, giving the name and address of the patient, the date, and the physician's signature or initials, which should be filed with the pharmacist in charge of the drug room before the cannabis leaves his charge. If, however, a prescription is used, reference to it should appear on the chart.

All prescriptions for cannabis must be dated as of and signed on the day when issued and must bear the full name and address of the patient and the name, address and cannabis registry number of the practitioner. Prescriptions should be written with ink or indelible pencil or be typewritten. If typewritten, the prescription should be of course signed by the physician. The refilling of a prescription for cannabis is prohibited by the regulations. Generally, the furnishing of cannabis pursuant to telephone advise of physician is prohibited, whether prescriptions covering such orders are subsequently received or not. In an emergency, however, a dealer may deliver cannabis through his employee or responsible agent pursuant to a telephone order, provided the employee or agent is supplied with a properly prepared prescription before delivery is made, such prescription to be turned over to the dealer and filed by him as required by law within a reasonable time after delivery. The government does not furnish prescription forms. Any form may be used, provided it is properly executed and shows the required information.

A physician who utilizes cannabis in the course of his professional practice should obtain a copy of the regulations that have been promulgated and familiarize himself with their requirements. Application for such a copy may be made to the collector of internal revenue of the collection district in which registration is to be effected.

NINTH GORGAS MEMORIAL ESSAY CONTEST ANNOUNCED

Announcement of the Ninth Gorgas Memorial Essay Contest has been made by Admiral Cary T. Grayson, Chairman of the Board of Directors of the Gorgas Memorial Institute, from the office of the institute at 1835 Eye Street, Northwest, Washington, D. C. The essay contests have become an annual feature of the program of personal health education carried on by the institute. High schools throughout the country are invited to enroll. Participation is restricted to students in the third and fourth years of high school.

For the best essay written in each school, a bronze Gorgas medal is awarded and the student so honored represents his school in the State competition. A prize of $10 in cash is given for the best essay in each State. The judges are state officials—the state health officer, state superintendent of education and the secretary of state. The state-prize-winning essays are then judged for the national awards. First Prize is $500 in cash and a travel al-

lowance of $200 for a trip to Washington to receive the prize. Second Prize is $150 in cash and Third Prize $50.

The subject for this year: The Achievements of William Crawford Gorgas and Their Relation to Our Health.

The dates of the contest: October 21, 1937 to January 21, 1938.

Full information concerning the contest may be found on school bulletin boards or can be obtained from the Gorgas Memorial Institute, Washington, D. C.

STATE NEWS ITEMS

Dr. Henry E. Palmer of Tallahassee, a past president of the Florida Medical Association, entertained a group of his friends on Tuesday evening, October 12, the occasion being the forty-fifth anniversary of his entering the practice of his profession in Tallahassee.

After a sumptuous buffet supper had satisfied the wants of the inner man, there was a feast of reason and a flow of heart-felt thoughts. Memories of the early days in Tallahassee were revived by the many old friends who had gathered for the occasion.

Doctor Palmer, a native of Jefferson County, graduated from the Medical Department of the University of Maryland in 1892, after which he served as assistant resident physician in the University Hospital for six months. He then entered the United States Public Health Service and was stationed at Fortress Monroe. This was followed by his entry into private practice in Tallahassee. In a short talk, Doctor Palmer related many amusing incidents that occurred in that city in the early days of his practice.

* * *

The annual scientific meeting of the Georgia Pediatric Society will be held in Atlanta on Thursday, December 9. Among the guest speakers will be Dr. Ralph S. Muckenfuss, Director of the Department of Health, Bureau of Laboratories, New York City; Dr. Priscilla White, attending physician, Deaconess Hospital, Boston, Massachusetts; and Dr. Joseph Brennemann, Professor of Pediatrics, University of Chicago and Chief of Staff, Children's Memorial Hospital, Chicago, Illinois.

Dr. J. R. Sory announces the removal of his offices to the Harvey Building, West Palm Beach. He was formerly located in Lake Worth.

* * *

Dr. and Mrs. Arthur Walters have returned to Miami Beach after three months in New England.

* * *

Dr. Charles L. Farrington of Tampa recently moved from New Orleans where he was senior resident in orthopedics and fractures at Charity Hospital and an associate in the Department of Orthopedics at Louisiana State University Medical Center.

Since June of this year, Doctor Farrington visited along the coastal countries of South America. While in Santos, Brazil, he found an account of his work done in the United States in one of the native papers. Doctor Farrington will limit his work to orthopedics and fractures.

* * *

Dr. and Mrs. M. A. Lischkoff have returned to Pensacola after having attended the meeting of the American Academy of Ophthalmology and Otolaryngology in Chicago where Doctor Lischkoff was elected to senior membership.

* * *

Dr. Frederick J. Waas of Jacksonville has returned from Rochester where he spent some time at the Mayo Clinic. He also attended the Clinical Congress of the American College of Surgeons in Chicago.

* * *

Dr. Raymond H. King of Jacksonville announces the opening of his offices at 709 Greenleaf Building. Doctor King will limit his practice to diseases of the ear, nose, throat, bronchoscopy and esophagoscopy.

* * *

Dr. G. C. Bottari of Tampa returned last month from an extensive European tour and course of study at clinics and hospitals.

* * *

The many friends of Dr. Ralph N. Greene of Coral Gables, formerly of Jacksonville, will regret to learn of the death of his mother, Mrs. Betty Green, early in October, in Indianapolis where she was visiting. Mrs. Greene had made her home with Doctor Greene in Coral Gables for over a year.

Dr. and Mrs. C. C. Mendoza of Jacksonville announce the birth of a son, Carl Clifford, Jr., October 12, in St. Vincent's Hospital.

* * *

Dr. J. Ralston Wells of Daytona Beach spent the month of October in the North. For three weeks he took special work at the Mayo Clinic; he attended the Clinical Congress of the American College of Surgeons in Chicago; and stopped off at Charlottesville, Va. for a visit with his eldest son who is enrolled at the University of Virginia.

* * *

Dr. and Mrs. S. A. Morris of Jacksonville spent some time in New York City during the month of October.

* * *

The Florida Dermatological Association held a clinical meeting in Tampa the weekend of October 23. A well attended skin clinic was held on Sunday. Cases were presented by Drs. C. A. Andrews and G. C. Bottari. Those in attendance were Drs. Alan Brown, Lauren Sompayrac, and J. L. Kirby-Smith, Jacksonville; Elmo D. French, Rothwell Lefholz, Buist Litterer, and Wiley Sams, Miami; Sam Ricker, Orlando; L. B. Mount, St. Petersburg; and J. A. Newnham, West Palm Beach.

* * *

President Edward Jelks announces that the pre-convention meeting of the Association will be held in Tampa, Sunday, January 16 at the Hillsborough Hotel. Dr. J. C. Vinson of Tampa is acting as chairman of the local committee on arrangements and full details will be announced in next month's Journal.

* * *

The officers, directors, and Program Committee of the Florida State Chamber of Commerce, through their president, Mr. Harold Colee, have extended an invitation to the members of the Florida Medical Association to be present and participate in the sessions of their business conference and Twenty-first Annual Meeting which will be held at the Colonial Orange Court Hotel in Orlando, December 6 and 7. The banquet will be held on the evening of December 6. All members of the Florida Medical Association have been most cordially invited to attend.

* * *

The American Medical Association and the National Broadcasting Company present each week over the Red Network a program of dramatized health messages intended to furnish graphic supplementary material for health teaching in junior and senior high schools. Much of this material is also useful for elementary schools, especially in the higher grades. The topics of the broadcasts, scheduled for 2 p. m., for the coming month are:

Nov. 24—Rest, Relaxation, Refreshment; all work and no play, or all play and no rest —bad for health.

Dec. 1—Tuberculosis, Foe of Youth: how bad habits of hygiene and unwise living, plus infection, favor tuberculosis.

Dec. 8—It Takes All Good Foods. A well rounded diet and how to get it.

Dec. 15—Milk from Farm to Table. The production, transportation, pasteurization and home care of milk; its place in the diet; processed milks.

Dec. 22—Vitamins, Minerals, and Common Sense. More about a balanced diet in special relation to minerals and vitamins.

JOHN M. MANN

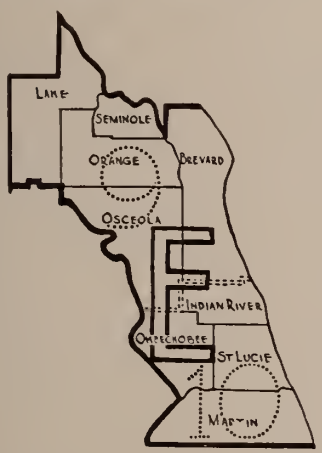
Dr. John M. Mann of Lake Butler died on November 6 of cerebral hemorrhage. He was born on February 8, 1876 at Lyons, Georgia, and received his education in that state, graduating from the Georgia College of Eclectic Medicine and Surgery, Atlanta, in 1910. He secured his license to practice in Florida the same year.

Since 1916, Doctor Mann has practiced in Lake Butler, during which time many honors have come to him. For seventeen years, he has been a member of the Florida State Board of Medical Examiners. At the time of his death, he was president of the Board for the second time. He served as Senator from his district in the Legislature during the 1933 and 1935 sessions. He was a Royal Arch Mason, member F. and A. M., Branford; W. O. W., Lake Butler; Director, Farmers and Dealers Bank; and a member of the Harmony Freewill Baptist Church.

Doctor Mann is survived by his widow, Nettie Howard Mann, to whom he was married in 1909; two sons, Howard of Gainesville and Hoyt of Lake Butler; two brothers and a sister.

ANNUAL MEETING
SOUTH CENTRAL DISTRICT

The first annual meeting of the South Central Medical District (E) was held at Melbourne, Thursday, October 21 at 3 p. m. The sessions were held at the club house of the Melbourne Golf and Country Club. The total registration was 44. Of this number 32 were doctors who are members of the county societies in this district; 2 were visiting doctors from Duval County; 1 from Dade County; 3 from Brevard County; 1 from Orange County; and 1 from Martin County. Firms having headquarters in this district, who exhibited at the Association's annual meeting, received an invitation to have their representatives attend this meeting. Accepting the invitation was Allan H. Campbell of Orlando, representing the Surgical Supply Company's branch office.



This is the fourth annual medical district meeting held so far this year. The representation from the membership in this district was exceptionally good. Almost forty per cent of the doctors holding membership in the component societies of this district attended the meeting. This splendid representation from organized medicine in the district emphasizes the importance of sectional meetings. They not only give the members an opportunity to meet the officers personally, but also afford an opportunity for becoming better acquainted and enjoying the good fellowship in a much closer relationship than is possible at a larger gathering.

Dr. I. M. Hay, Chairman of the Local Committee on Arrangements, with his associates, entertained most graciously. Elaborate preparations had been made before the doctors assembled and every detail was carefully planned far in advance. The assembly room at the club house was an ideal place to meet, being located on the second floor with windows and porches on two sides. Comfortable chairs and upholstered lounges were arranged around the room so that every comfort of those at this meeting was carefully looked after.

At 3:05 p. m., Dr. W. C. Page, Senior Councilor, called the meeting to order. The address of welcome was delivered by Dr. I. M. Hay, Chairman of the Local Committee on Arrangements. The first paper was read by Dr. C. J. Collins of Orlando, the subject being "Abnormal Bleeding in the Middle-Aged Woman." The second paper was by Dr. E. W. Potthoff of Titusville, on "Common Skin Diseases in General Practice." The last scientific paper was read by Dr. E. L. Jewett of Orlando on "Bone Injuries in General Practice." The scientific papers were well presented and the close attention of those present was a compliment to the essayists.

Very constructive discussions followed the presentation of the papers, which added to their value. At the close of the scientific session, Dr. R. D. Thompson, Superintendent of the State Tuberculosis Sanatorium at Orlando, was recognized by the presiding officer, Doctor Page. Doctor Thompson explained conditions in the Sanatorium, its functions and necessity. He also emphasized the fact that all communications directed to the State Tuberculosis Sanatorium should be addressed to Orlando.

After a short recess the general session was opened with Dr. H. D. Clark, Junior Councilor, presiding. Dr. Edward Jelks, the Association's president, was first called upon and gave a brief address on the State Association's affairs, functions of various committees, and problems to be faced. Dr. W. C. Page, Senior Councilor, was then recognized. Doctor Page gave an outline of the plans of the Council, as originated at their first annual meeting held in Orlando last June. His report emphasized the activities of the various councilors and the contribution they are making to organized medicine. President-elect W. Henry Spiers was then recognized. Doctor Spiers very briefly outlined some of the plans he is making for next year's activities. Dr. John S. McEwan, a past president from this district, was

then recognized. Dr. Gilbert S. Osincup, Chairman of the Executive Committee, was also called upon. Dr. T. Z. Cason, Chairman of the Committee on Medical Postgraduate Course was present but was not called upon owing to the fact that President Jelks had emphasized in his address the importance of this particular committee and outlined the plans that have been formulated.

The next order of business was the selection of a meeting place for 1938. Dr. Frank H. Harms, President of the Orange County Medical Society, extended an invitation to meet at Orlando. Dr. H. G. Holland extended an invitation on behalf of the doctors in Leesburg. Doctor McEwan was recognized and mentioned that the Orlando doctors would be very happy indeed to have the next annual meeting held in their city. Having the good of the organization at heart, he brought out the point, however, that many meetings of medical groups have been held in Orlando and that the purpose of the district medical meetings is to become better acquainted in the smaller cities. Doctor McEwan stated that a district meeting is not too large to hold its sessions in a smaller city where it would be impossible to entertain the State Association or large medical groups. The question as to the next meeting place was then put and, by unanimous vote, Leesburg was designated as the meeting place of the second annual meeting in the South Central Medical District.

There being no further business, Doctor Hay announced that the next hour would be spent in relaxation. Light refreshments were served during this hour and a very pleasant time was enjoyed by the various doctors who congregated around in small groups, discussing some of the questions concerning their profession, story telling, and renewing old acquaintances. At 6:30 p. m. the dinner bell sounded and the group was ushered into a large dining room where a horseshoe table was laden with a bounteous supply of the most appetizing food. The doctors of the host society made ample provision to satisfy the most extravagant appetite. There was no registration fee, as the entertaining society not only took care of the cost of the dinner, but also all other refreshments served during the afternoon.

The program after dinner was informal. Doctor Hay, who presided, called on Dr. T. A. Neal of Orlando to act as toastmaster. Doctor Neal called on various doctors present for extemporaneous speeches and the hearty laughs by those present amid the hilarious applause, spurred some of the speakers on to real oratorical eloquence. The enthusiasm ran so high that the toastmaster finally decided it would not be possible to expose the group to all the oratory talent available and, at a late hour, announced that the time for adjournment had arrived. By a rising vote, the host society was thanked for its wonderful hospitality.

REGISTRATION

W. C. Page, *Senior Councilor* ..... Cocoa
H. D. Clark, *Junior Councilor* ..... Ft. Pierce
Stewart G. Thompson, *Managing Director,* Jacksonville

MEMBERS

Andrews, Mitchell M. ..... Orlando
Bean, I. F. ..... Melbourne
Booth, R. C. ..... Ft. Pierce
Brame, Dorothy D. ..... Orlando
Buff, J. H. ..... Orlando
Christie, G. E. ..... Titusville
Collins, C. J. ..... Orlando
Council, M. D. ..... Ft. Pierce
Creel, W. J. ..... Eau Gallie
Hardee, E. B. ..... Vero Beach
Hardie, G. C. ..... Ft. Pierce
Harms, Frank H. ..... Orlando
Hart, Ruth S. ..... Winter Park
Hay, I. M. ..... Melbourne
Holland, H. G. ..... Leesburg
Ingram, L. C. ..... Orlando
Jewett, Eugene L. ..... Orlando
Johnston, Hewitt ..... Orlando
Kenaston, T. C. ..... Cocoa
Knowles, H. S. ..... Orlando
McDaniel, T. F. ..... Sanford
McEwan, J. S. ..... Orlando
Neal, T. A. ..... Orlando
O'Kelley, M. B. ..... Leesburg
Orr, Louis M., II ..... Orlando
Osincup, Gilbert S. ..... Orlando
Pines, J. A. ..... Orlando
Potthoff, E. W. ..... Titusville
Ricker, S. F. ..... Orlando
Spiers, W. Henry ..... Orlando
Thompson, R. D. ..... Orlando
Whiddon, L. L. ..... Ft. Pierce

GUESTS FROM F. M. A.

Burns, V. W. ..... Stuart
Cason, T. Z. ..... Jacksonville
Gowdy, F. A. ..... Ft. Pierce
Jelks, Edward ..... Jacksonville

VISITORS

Benton, G. H. ..... Melbourne
Campbell, Allan H. ..... Orlando
Hicks, I. K. ..... Melbourne
Phillips, G. M. ..... Eau Gallie
Robertson, Don C. ..... Orlando

INTERNATIONAL MEDICAL ASSEMBLY

There are several features of the International Medical Assembly that distinguish it from other medical organizations but the two chief differences are that it is free from politics and it is not divided into sections. The purpose of these meetings is to better familiarize the doctors who practice specialties as well as general practitioners with the new and better aids to diagnosis and the practice of medicine.

To accomplish this, the Program Committee has selected instructors who are outstanding in their particular lines, from the better schools of North America and Europe. These instructors, who give lectures and conduct clinics are not only conversant with their subjects, but have the proper conception of the practice of medicine in general, to convey their findings in these clinics to the audience.

Any doctor who desires foreign study may go to Europe or South America on one of the all-expense-prepaid tours of this organization and attend lectures and clinics at the chief medical centers of the country selected for the tour.

Dr. Elliott P. Joslin of Boston was elected president for the coming year at the meeting of the Assembly held at St. Louis, October 18 to 22, and Philadelphia was selected as the next meeting place. The following Florida doctors attended the St. Louis meeting:

Alsobrook, J. W.	Plant City
Aronovitz, Samuel	Miami
Britt, Reddin	St. Augustine
Christ, C. D.	Orlando
Colley, S. C.	Tavares
Driskell, S. E.	Jacksonville
Grable, James S.	Tampa
Gurganious, Allen P.	Palatka
Hanson, Karl B.	Jacksonville
Hargrove, J. L.	Bartow
Hodsdon, Benjamin F.	Miami
Hughes, Victor A.	Jacksonville
McKinnon, D. A.	Marianna
Maines, John E., Jr.	Gainesville
Morris, Kenneth A.	Jacksonville
Oetjen, Leroy H.	Leesburg
Rector, Lee T.	Tampa
Roberts, Earl H.	Jacksonville Beach
Tomlinson, J. P., Jr.	Lake Wales

FLORIDA MIDLAND MEDICAL SOCIETY MEETING

The fall meeting of the Florida Midland Medical Society was held at the Shrine Club in St. Petersburg at 2 p. m., October 28, 1937, with an attendance of 48. President C. W. Larrabee of Bradenton, presided. The following scientific program was presented:

"Congenital Abnormalities of the Intestinal Tract," T. C. Maguire, Plant City. Discussion by W. D. Sugg, Bradenton, and E. Bryant Woods, Tampa.

"Malaria—Factors To Be Considered In Its Treatment," M. M. Harrison, Bradenton. Discussion by C. A. Williams, St. Petersburg; R. L. Cline, Lakeland; G. C. Bottari, Tampa; Gideon Timberlake, St. Petersburg; and J. T. Moore, Tampa.

"A Palliative Treatment of Acute Mastoiditis," M. H. Stuart, St. Petersburg. Discussion by R. L. Cline, Lakeland.

"Birth Injuries," E. Bryant Woods, Tampa. Discussion by W. P. Adamson, Tampa, and Fred Albee, Venice.

"Bone Graft of the Neck of the Femur" (Illustrated), Harold C. McDowell, Venice. Discussion by Fred Albee, with colored film for illustration.

"The Known and Unknown Factors in Tuberculosis," Arnold S. Anderson, St. Petersburg.

"Carcinoma of the Urinary Bladder:
"Surgical Considerations," Robert B. McIver, Jacksonville.

"Pathological Types," L. Y. Dryenforth, Jacksonville. Discussion by James L. Estes, Tampa.

Following the scientific program, a well-prepared dinner was enjoyed at 7 p. m. and the following officers were elected to serve during the year 1938: President, W. C. McConnell, St. Petersburg; First Vice-President, W. E. Sinclair, Orlando; Second Vice-President, John T. Moore, Tampa; Secretary-Treasurer, B. H. Sanchez, Plant City. Orlando was selected as the place of the next meeting, which will be held April 28, 1938.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

At the meeting of the Dade County Medical Society held on the evening of October 5, the scientific program consisted of a paper by Dr. E. H. Adkins on "A Case of Ptosed Spleen with Torsion in a Male—Splenectomy." Honorable George E. Holt, representative from Dade County to the State Legislature, made an interesting talk on the ways in which laws are enacted.

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DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The regular monthly meeting of the DeSoto-Hardee-Highlands County Medical Society was held at the Simmons Hotel in Wauchula, Tuesday evening, October 12 at 8:00 o'clock.

After the regular business session Congressman Peterson gave a very instructive talk on recent legislation affecting the medical profession and other happenings in Congress that were of general interest. Following the guest speaker's address the entire group entered into a round-table discussion which was thoroughly enjoyed.

Members present included Drs. Bevis, Boorom, Highsmith, Kayton, Kirkpatrick, McSwain, Martin, Poucher, and Spears. Visitors were Doctors Philpot and Pyatt, Bowling Green; Dr. H. W. Martin, dentist of Sebring; and Hon. J. Hardin Peterson, Lakeland.

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DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society held its regular monthly meeting on Tuesday evening, November 2, in the State Board of Health Building, Jacksonville. No scientific program was presented inasmuch as this meeting had been set aside to give the members of the Society an opportunity to discuss and vote on a fee schedule for industrial cases. A representative of the local claim men was present and spoke on compensation medical work. Refreshments were served after the business meeting.

* * *

ORANGE COUNTY MEDICAL SOCIETY

THE ORANGE COUNTY MEDICAL SOCIETY HAS JOINED THE GROUP OF SOCIETIES WHICH ARE 100 PER CENT PAID FOR 1937. TEN NEW MEMBERS HAVE BEEN ADDED TO THE SOCIETY THIS YEAR, WHICH HAS BROUGHT THE TOTAL MEMBERSHIP UP TO 65—63 ACTIVE AND 2 HONORARY. CREDIT MUST GO TO THE FOLLOWING OFFICERS OF THE SOCIETY FOR GOOD WORK WELL DONE: F. H. HARMS, ORLANDO, PRESIDENT; H. A. DAY, ORLANDO, VICE-PRESIDENT; HEWITT JOHNSTON, ORLANDO, SECRETARY; SPENCER A. FOLSOM, ORLANDO, TREASURER.

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PINELLAS COUNTY MEDICAL SOCIETY

THE PINELLAS COUNTY MEDICAL SOCIETY STANDS 100 PER CENT PAID FOR 1937, WITH A MEMBERSHIP OF 86 ACTIVE AND 3 HONORARY MEMBERS. THE OFFICERS FOR 1937 UNDER WHOM THIS SPLENDID RECORD WAS ACHIEVED WERE: PRESIDENT, NORVAL M. MARR; FIRST VICE-PRESIDENT, E. C. MACCORDY; SECOND VICE-PRESIDENT, L. W. HORNE; SECRETARY-TREASURER, W. C. McCONNELL.

At a recent meeting of the Pinellas County Medical Society, officers for the year 1937-1938 were elected, as follows: President, J. A. Strickland; First Vice-President, J. A. Herring; Second Vice-President, F. H. Langley; Secretary-Treasurer, W. C. McConnell.

This Society was the first in the State to report dues for 1938. Already, almost one-half of their State dues for the coming year have been received at headquarters. Congratulations go to the old and the new regime.

The following committees have been appointed:

Executive, Drs. Strickland, MacCordy, Herring, Langley, McConnell; Censors, Drs. Davis, Marr, N. W. Gable, Jr., Winchester, LeBreton, Murphy; Scientific Program and Entertainment, Drs. MacCordy, A. S. Anderson, W. D. Anderson, Knowlton; Public Health, Legislation and Medical Economics, Drs. Herring, Davis, Wood, Winchester; Necrology, Drs. Langley, Williams, Harden; Counselor to the Auxiliary, Doctor Frederick.

Florida Medical Special

To SOUTHERN MEDICAL ASSOCIATION



NEW ORLEANS, LOUISIANA

For the convenience of members attending the 31st Annual Meeting of the Southern Medical Association, November 30th - December 3rd at New Orleans, Louisiana, THE SEABOARD AIR LINE RAILWAY, the OFFICIAL ROUTE, offers the following schedules and fares from Florida points to New Orleans:

Lv. Miami	S. A. L.	8.25 am	ar	10:00 pm
Lv. West Palm Beach	S. A. L.	10:10 am		11:45 pm
Lv. St. Petersburg	S. A. L.	11:05 am		9:10 pm
Lv. Clearwater	S. A. L.	11:46 am		10:05 pm
Lv. Tampa*	S. A. L.	1:00 pm		11:50 pm
Lv. Ocala*	S. A. L.	3:43 pm		5:34 am
Lv. Jacksonville	S. A. L.	9:35 pm		11:35 am
Ar. New Orleans	L. & N.	7:40 pm		7:45 am

*Streamlined motor coach leaving Tampa 7:00 A.M. and Ocala 9:50 A.M. makes connection at Baldwin with train leaving Jacksonville at 11:35 A.M.

ROUND TRIP FARES. 15 DAY LIMIT

Clearwater	$36.00	Ocala	$30.10
Daytona Beach	32.55	Orlanda	33.40
Fort Myers	39.25	Palatka	30.10
Fort Pierce	38.50	Sanford	33.25
Gainesville	28.65	St. Petersburg	36.85
Jacksonville	27.60	Tampa	35.05
Lakeland	34.95	Winter Haven	35.25
Miami	44.10	West Palm Beach	41.10

PROPORTIONATE FARES FROM OTHER POINTS. TICKETS ON SALE DAILY

PULLMAN RATES: Jacksonville-New Orleans (one way)

Lower Berth, $4.25; Upper Berth, $3.40; Compartment, $12:00; Drawing Room, $15.00

Special sleepers will be operated from Jacksonville to New Orleans.

Reservations: Apply to any SEABOARD AIR LINE RAILWAY TICKET AGENT or W. J. Kenealy, General Passenger Agent, 233 West Forsyth St., Jacksonville, Fla.

SOUTHERN MEDICAL ASSOCIATION

31ST. ANNUAL MEETING

at

NEW ORLEANS

the

CRESCENT CITY

NOV. 30 - DEC. 1-2-3

THE WORTH OF MEDICAL MEETINGS to the physician is not the purpose of this announcement since the alert profession has come to recognize the value of keeping abreast through this channel. Rather, the purpose is to urge physicians to attend more medical meetings regularly.

Of particular interest to the profession in the South are the annual meetings of the Southern Medical Association where clinical sessions, eighteen sections and an expanse of scientific and technical exhibits constitute a four day education in the later developments of scientific medicine.

Surely, the meeting this yea. in New Orleans will be one well chosen for the specialist or general practitioner alike; the program will afford keen interest to both in the wide variety of meetings and exhibits, all being housed under one roof, the Municipal Auditorium.

New Orleans, often called "America's Most Interesting City," is indeed a delightful setting for pleasure and relaxation when the program of the day is over.

ALL MEMBERS OF STATE AND COUNTY medical societies in the South are cordially invited to attend. And all members of state and county medical societies in the South should be and can be members of the Southern Medical Association. The annual dues of $4.00 include the Southern Medical Journal—the equal of any, better than many.

SOUTHERN MEDICAL ASSOCIATION

Empire Building

BIRMINGHAM, ALABAMA

ON TO NEW ORLEANS

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The Southern Medical Association was founded by the leaders of medicine in the Southland. It has grown at such a remarkable rate that today it is the second largest medical society in the world. A number of members of the Florida Medical Association have been honored by the Southern. Florida has had the honor of having two presidents, the late Dr. J. M. Jackson of Miami and Dr. H. Marshall Taylor of Jacksonville. Dr. R. H. McGinnis of Jacksonville has served as vice-president; Dr. J. Lee Kirby-Smith of Jacksonville has served as secretary of the Section of Dermatology; and Dr. Luther W. Holloway of Jacksonville has served as chairman of the Section of Pediatrics.

A preliminary program of the New Orleans meeting has been mailed to every member of the Florida Medical Association. A special feature of the meeting will be the conference of presidents, presidents-elect, and secretaries of the states comprising the Southern Medical Association. All the above named officers are most cordially invited to attend the conference. Dr. Harvey F. Garrison of Jackson, Mississippi, former president of the Mississippi State Medical Association, who originated the idea of this conference and who acted as chairman for the Baltimore conference, has accepted an invitation to act as chairman of the New Orleans conference. A formal invitation to the dinner will go forward to all presidents, presidents-elect, and secretaries of state medical associations.

The Seaboard Air Line Railway is the official route to New Orleans from Florida and it has arranged special sleeping cars to take care of the delegates. Those who plan to attend should contact their local Seaboard Air Line Railway ticket agent and he will be glad to make reservations to take care of transportation.

ABSTRACT DEPARTMENT

Kenneth A. Morris, M.D., Abstract Editor

Hyperpyrexia in Bronchial Asthma—Phillips, Kenneth, Miami, Florida,*Arch. Phys. Therapy*, 17:282-288 (May) 1936.

According to the author, it is a common observation that fever, associated with infectious diseases, may temporarily control the symptoms of allergic disease. Attempts to produce fever in allergic people by a foreign protein, malaria or a relapsing fever is dangerous. The following control factors should be rigidly observed: "(1) a sufficiently large number of patients including their variations of age, sex, type, and duration; (2) prolonged period of controlled observation; (3) a detailed study of both clinical and biologic reactions, both immediate and subsequent." The author has a record of over 250 cases observed from six months to three years. The following conclusions were reached: (1) that fever therapy by physical means as a specific in the treatment of bronchial asthma is of practically no value except as a temporary measure; (2) when it is used in conjunction with other measures it becomes one of the most valuable adjuncts in therapy. At the present time, the author is observing a group in which the temperature is elevated to only 101 and 102 degrees F for 45 minutes daily. He believes that this technique might prove to be the most appropriate. The subject of hyperpyrexia produced by physical means with special attention to bronchial asthma is reviewed. The author who shared personally in the pioneering of this work believes that this report will tend to dampen the over-enthusiast and encourage some of the early workers who gave up the method as a failure.

Infectious Diarrheas in Children — Rose, Joseph, Jacksonville, and Schapiro, M. M., Washington, D. C., *M. Ann. District of Columbia*, 6:64-66 (March) 1937.

From 1933 to March, 1937, there were 750 cases of diarrhea treated in the Children's Hospital, Washington, D. C. Of these, 556 cases were simple non-infectious diarrhea, either alone or complicating some other disease. There were 194 cases of true infectious etiology. The diagnostic technique of the laboratory staff is stressed. Three samples of stools are taken the same day with a sterile catheter and innoculation is made onto a brain-heart infusion broth for one-half hour at 37 degrees C. "A suspension of this mixture is then transferred to eosin-methylene blue and blood agar plates and incubated for 24 hours. The plates are then examined for typical colony formation and fermentation by the streptococci, staphylococci, and organisms of the typhoid-dysentery group. Colonies of the typhoid-dysentery group are then transferred to Russell's double sugar (stab method) and incubated for 24 hours. The acid tubes are discarded. . . . Alkaline slants with acid butts indicate a member of the typhoid-dysentery group; gas formation is indicative of the typhoid bacillus. Representative suspected colonies are then transferred to maltose, dextrose, lactose, mannite, and saccharose broth, incubated for 24 hours and examined for gas and acid formation. The final diagnosis is based on indole fermentation and the microscopic demonstration of motility." The authors believe that it is of interest to note that the greatest number of cases found in the District of Columbia were due to Eberthella paradysenteriae Hiss; whereas, in Maryland, West Virginia and New York, 25 to 80 per cent of the cases are paradysenteriae Flexner. Contrary to the findings of Talbot that the condition is most frequently seen in the hot summer months, July and August, the authors found the mean height incidence of four years to be in September. The greater majority of the 194 cases of infectious diarrhea were in Negroes. They believe this due mainly to their socio-economic status and accompanying ignorance. In the artificially fed babies at the Thomas Wilson Sanitarium Welfare Clinics at Baltimore, 50 per cent remained well; 33 per cent developed simple diarrhea and 17 per cent had typical dysentery. Of the breast fed babies, 10 per cent developed simple diarrhea and none developed dysentery. The authors also conclue that artificial feeding and the socio-economic status of the family are important elements in the development of diarrhea.

An article on "Tetanus," which was presented by Dr. Joseph Stewart of Miami before the Sixty-fourth Annual Meeting of the Florida Medical Association and published in the September issue of our Journal, has beeen abstracted by the Journal of the A. M. A. This abstract appears on page 1578 of the November 6 issue.

CONSTITUTION

ARTICLE I
Name of the Association

The name and title of this organization shall be the Florida Medical Association, Incorporated.

ARTICLE II
Purposes of the Association

The purposes of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of Florida, and to unite with similar Associations in other States to form the American Medical Association, with a view to the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians, and to the guarding and fostering of their material interests; and to the enlightenment and direction of public opinion in regard to the great problems of State medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III
Component Societies

Component Societies shall consist of those county medical societies which hold charters from this Association.

ARTICLE IV
Composition of the Association

Section 1. This Association shall consist of Members, Delegates, Life Members, Honorary Members, and Guests.

Sec. 2. *Members*—The members of this Association shall be the members of the component county medical societies.

Sec. 3. *Delegates*—Delegates shall be those members who are elected in accordance with this Constitution and By-Laws to represent their respective component societies in the House of Delegates of this Association.

Sec. 4. *Life Members*—Any member of the Florida Medical Association who has been an active member of the Association for 35 years shall be made a life member of the Association and exempt from all dues.

Sec. 5. *Honorary Members*—Honorary and retired members of the Florida Medical Association may be elected by the House of Delegates or by the Executive Committee either directly or upon nomination officially made by a component County Medical Society. An honorary or retired member shall be exempt from all dues in this Association; shall not have the right to vote; shall be permitted to subscribe for the publication of the Association at a special price to be made by the House of Delegates or Executive Committee; shall have the right to attend meetings and be eligible to such other privileges as may be granted by the House of Delegates.

Sec. 6. *Guests*—Any distinguished physician may become a guest during any Annual Meeting upon invitation of the officers of this Association, and shall be accorded the privilege of participating in all of the scientific work for that Meeting.

ARTICLE V
House of Delegates

The House of Delegates shall be the legislative and business body of the Association, and shall consist of (1) Delegates elected by the component county societies, and (2), *ex-officio*, the officers of the Association as defined in this Constitution.

ARTICLE VI
Meetings and Sessions

Section 1. The Association shall hold an Annual Meeting during which there shall be held daily not less than two Sessions which shall be open to all registered members, delegates, honorary members, life members and guests.

Sec. 2. The Association shall hold an Annual Meeting at the place selected by the House of Delegates at the preceding Annual Meeting. The date shall be fixed by the Executive Committee with the approval of the Committee on Arrangements of the entertaining society at least four months in advance.

Sec. 3. Special Meetings of either the Association or the House of Delegates may be called by the President.

ARTICLE VII
Officers

Section 1. The Officers of this Association are to be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer, and an Editor of the Journal. In the discretion of the Association, the offices of Secretary, Treasurer and Editor of the Journal may be held by one individual.

Sec. 2. All Officers are to be elected annually, and shall serve until their successors are elected and installed.

Sec. 3. The Officers of this Association shall be elected by the Association at noon on the last day of the Annual Meeting, and any member shall be eligible to any office named in the preceding section, but no person shall be elected to such an office who is not in attendance during that Annual Meeting (except the Secretary, Treasurer and Editor of the Journal) and who has not been a member of the Association for two years.

Sec. 4. THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC., shall be the official organ of the Association.

ARTICLE VIII
Arrangement for Funds

Funds for meeting expenses of the Association are to be arranged for by the House of Delegates, by an equal per capita assessment on each county society to be fixed by the House of Delegates, or by voluntary contributions or bequests, and by profits of publications. Funds may be provided by the House of Delegates to defray the expenses of the Annual Meetings, for publications, and for such other purposes as it may deem proper.

ARTICLE IX
Referendum

The General Session of the Association may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may by a similar vote of its own members, or after a like vote of the General Session, submit any such question to the membership of the Association for a final vote; and if the persons voting shall comprise a majority of all the members, a majority of such vote shall determine the question, and be binding upon the House of Delegates.

ARTICLE X
The Seal

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

ARTICLE XI
Amendments

Any article of the Constitution may be amended by two-thirds vote of the Delegates registered at that Annual Meeting and referred to the component county societies for ratification during the ensuing year; each society ratifying by majority vote of its members present at any regular meeting; it being necessary for three-fourths of the component societies to vote in favor of its ratification during the year.

BY-LAWS

Chapter I
Membership

Section 1. All members of Component Societies shall be privileged to attend all sessions and take part in all of the proceedings of the Annual Meeting, and shall be eligible to any office within the gift of the Association.

Sec. 2. The name of a physician upon the properly certified roster of members, or list of delegates, of a component society which has paid its annual assessment, shall be *prima facie* evidence of his right to register at the Annual Meeting in the respective bodies of this Association.

Sec. 3. No person who is under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take any part in any of its proceedings until such time as he has been relieved of such disability.

Sec. 4. Each member in attendance at the Annual Meeting shall enter his name on the registration book, indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of his society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of an Annual Meeting until he has complied with the provisions of this section.

Chapter II
General Sessions

Section 1. The General Sessions shall include all registered members, delegates, honorary members, life members and guests, who shall have equal rights to participate in the proceedings and discussions and, except honorary members and guests, to vote on pending questions. Each General Session shall be presided over by the President, or in his absence or disability, or by his request, by one of the Vice-Presidents. Before it, at such time and place as may have been arranged, shall be delivered the annual address of the President, and the annual oration, and the entire time of the Meeting so far as may be shall be devoted to papers and discussions relating to scientific medicine.

Sec. 2. The General Session shall have authority to create committees or commissions for scientific investigations of special interest and importance to the profession and public, and to receive and dispose of reports of the same, but any expense in connection therewith must first be approved by the House of Delegates or the Executive Committee.

Sec. 3. Except by special vote, the order of exercises, papers and discussions as set forth in the official program shall be followed from day to day until it has been completed.

Sec. 4. No address or paper before the Association, except those of the President and Orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once, on any one subject.

Sec. 5. All papers read before the Association shall be its property. Each paper shall be deposited with the Secretary when read.

Chapter III
House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Meeting of the Association, and shall so fix its hours of meeting as not to conflict with the first General Session of the Association, or with the session held for the address of the President and the annual oration, and so as to give delegates an opportunity to attend the other scientific proceedings and discussions so far as is consistent with their duties. But if the business interests of the Association and profession require, it may meet in advance, or remain in session after the final adjournment of the Annual Meeting, or meet at the call of the President.

Sec. 2. Each component county society shall be entitled to send to the House of Delegates each year one delegate for every 20 members, and one for each major fraction thereof, but each county society holding a charter from this Association, which has made its annual report and paid its assessment as provided in this Constitution and By-Laws, shall be entitled to one delegate. Provided, that this annual report must be made to the Secretary of the State Association at least thirty days prior to the date of the Annual Meeting.

Sec. 3. A majority of the registered delegates shall constitute a quorum, and all of the sessions of the House of Delegates shall be open to members of the Association. Ample seating facilities shall be arranged for the House of Delegates, separate and apart from the seating facilities provided for visiting members of the Association.

Sec. 4. It shall, through its officers, Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping-stone to future ones of higher interest.

Sec. 5. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical information in relation thereto.

Sec. 6. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every physician in every county of the State who can be made reputable has been brought under medical society influence.

Sec. 7. It shall encourage postgraduate work in medical centers, as well as home study and research, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 8. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body in such a manner that not more than one-half, as near as may be, shall be elected in any one year.

Sec. 9. It shall, upon application, provide and issue Charters to county societies organized to conform to the spirit of this Constitution and By-Laws.

Sec. 10. In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies, and these societies when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 11. It shall divide the State into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each a district medical society, and all members of component county societies, and no other, shall be members in such district societies.

Sec. 12. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates, and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Sec. 13. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 14. It shall publish its proceedings in THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

Sec. 15. It shall select the place for the next annual meeting upon recommendation of the Executive Committee.

Sec. 16. Each delegate representing a component society, before being seated, shall deposit with the Association's secretary or his duly authorized representative, a certificate signed by the Secretary of his component society, stating that he has been regularly elected a delegate by the component society. All delegates shall report at the registration desk upon arrival at the state meeting, exhibit their credentials and receive instructions regarding the meeting place and time of House of Delegates.

CHAPTER IV
Election of Officers

All elections shall be by secret ballot, unless there is but one nominee for an office when the Secretary, upon motion duly seconded and carried, is empowered to cast the ballot of the Association for the nominee. A majority of the votes cast shall be necessary to elect.

CHAPTER V
Duties of Officers

Section 1. The President shall preside at all meetings of the Association and of the House of Delegates; shall appoint all committees not otherwise provided for; shall deliver an annual address at such time as may be arranged; shall give a deciding vote in case of a tie, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the State and assist the Councilors in building up the county societies, and in making their work more practical and useful.

Sec. 2. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of his death, resignation or removal, the First Vice-President shall succeed him. The President - elect shall be *ex-officio* member of all committees, without the power to vote.

Sec. 3. The Treasurer shall give bond in the amount of his yearly budget. He shall demand and receive all funds due the Association, together with bequests and donations, and shall have the care and arrangement of fiscal affairs of the Association. He shall subject his accounts yearly to audit by a Certified Public Accountant, and render an annual report of his doings to the second General Session of the Association. He shall charge upon his books the assessments upon each component county society at the end of the fiscal year, which assessments he shall collect and make the proper credit for, and he shall perform such other duties as may be assigned him. All funds belonging to the Association shall be deposited in a National Bank to the credit of the Association. No money shall be drawn from this account except by proper voucher checks, serially numbered. The expenses of the Treasurer's bond and audit of accounts, shall be paid by the Association.

Sec. 4. The Secretary shall attend all sessions of the Association and of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association which come into his hands. He shall provide for the registration of members and delegates at the Annual Meetings. He shall keep a record of all the legal practitioners of the State, noting their status in relation to their county societies, and upon request shall transmit a copy of this list to the American Medical Association for publication. Insofar as it is in his power, he shall use the printed matter, correspondence and influence of his office to aid the Councilors in the organization and improvement of the county societies and in the extension of the power and usefulness of this Association. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He may employ such assistance as may be authorized by the House of Delegates or the Executive Committee. He shall annually make a report of his doings to the second General Session of the Association. In order that the Secretary may be enabled to give that amount of time to his duties which will permit of his becoming proficient, it is desirable that he should receive some compensation. The amount of his salary shall be $600.00 per annum.

CHAPTER VI
Council

Section 1. The Council shall consist of one Councilor from each of the following districts: *Councilor District No. 1,* comprising the following counties: Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, and Bay. *Councilor District No. 2,* comprising the following counties: Jackson, Calhoun, Gulf, Gadsden, Liberty, Franklin, Leon, Wakulla, and Jefferson. *Councilor District No. 3,* comprising the following counties: Madison, Taylor, Hamilton, Suwannee, Lafayette, Columbia, Dixie and Baker. *Councilor District No. 4,* comprising the following counties: Alachua, Marion, Levy, Citrus, Sumter, Hernando, Pasco, Gilchrist, Bradford and Union. *Councilor District No. 5,* comprising the following counties: Duval, Nassau, Clay, and St. Johns. *Councilor District No. 6,* comprising the following counties: Volusia, Flagler, and Putnam. *Councilor District No. 7,* comprising the following counties: Hillsborough, Pinellas, Manatee, and Sarasota. *Councilor District No. 8,* comprising the following counties: Polk, Hardee, DeSoto, Highlands, Charlotte, Lee, Glades, Hendry, and Collier. *Councilor District No. 9,* comprising the following counties: Lake, Orange, Osceola, Brevard and Seminole. *Councilor District No. 10,* comprising the following counties: Indian River, Okeechobee, St. Lucie, and Martin. *Councilor District No. 11,* comprising the following counties: Palm Beach and Broward. *Councilor District No. 12,* comprising the following counties: Dade and Monroe.

Upon the adoption of this amendment, the incoming President shall appoint one Councilor for each district, six for one year and six for two years, and thereafter they shall be appointed for two years as the terms expire. The President shall select the Chairman of the Council. The Council shall, through its Chairman, make an annual report to the first session of the House of Delegates.

Sec. 2. Each Councilor shall be organizer, peacemaker and censor for his district. He is urged to visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his doings, and of the condition of the profession of each county in his district to each annual session of the Council.

Sec. 3. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies or to this Association. All questions of an ethical nature brought before the House of Delegates, or the general sessions, must originate in the county society and shall be referred to the Council without discussion.

CHAPTER VII
Committees

Section 1. Regular committees shall be the Executive Committee (or may be called the Board of Governors) (Section 2); a Committee on Scientific Work (Section 3); a Committee on Legislation and Public Policy (Section 4); a Committee on Publication (Section 5); a Committee on Medical Education and Hospitals (Section 6); a Committee on Public Relations (Section 7); a Committee on Necrology (Section 8); a Committee on Medical Postgraduate Course (Section 9); a Com-

mittee on Cancer Control (Section 10); a Committee on Medical Economics (Section 11); an Inter-relationship Committee (to work with similar committees from allied professions—dentists, druggists and nurses) (Section 12); a Committee on Tuberculosis and Public Health (Section 13); a Committee on State Controlled Medical Institutions (Florida State Hospital and Florida Farm Colony) (Section 14); a Committee on Maternal Welfare (Section 15); a Committee on Child Health (Section 16); an Advisory Committee to the Woman's Auxiliary (Section 17); a Committee as Representatives to the Industrial Council (Section 18); a Committee on Venereal Disease Control (Section 19). They shall be appointed by the President as hereinafter prescribed. The Committee on Arrangements shall consist of the component society where the annual meeting of the Association is to be held (Section 20).

The Florida Medical Association shall be divided into six committee districts as follows: Northwest, North Central, Northeast, Southwest, South Central and Southeast districts. The *Northwest District* (A) to include the following counties: Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, Bay, Jackson, Calhoun, Gulf, Gadsden, Liberty, Franklin, Leon, Wakulla, and Jefferson. The *North Central District* (B) to include Madison, Taylor, Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Baker, Union, Bradford, Alachua, Marion, Citrus, Sumter, Hernando, and Pasco Counties. The *Northeast District* (C) to include Nassau, Duval, Clay, St. Johns, Putnam, Flagler, and Volusia Counties. The *Southwest District* (D) to include Hillsborough, Pinellas, Manatee, Sarasota, Polk, Hardee, DeSoto, Charlotte, Lee, Highlands, Glades, Hendry, and Collier Counties. The *South Central District* (E) to include Lake, Orange, Seminole, Osceola, Brevard, Indian River, Okeechobee, St. Lucie, and Martin Counties. The *Southeast District* (F) to include Palm Beach, Broward, Dade and Monroe Counties.

Sec. 2. The Executive Committee (or Board of Governors) shall consist of the President and Secretary, *ex-officio,* and six members, one from each district, to be appointed by the President. Upon the adoption of this amendment to the By-Laws, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereafter they shall be appointed for three years as the terms expire. The President shall select the Chairman of this Committee. It shall consider and act upon all matters of business pertaining to the Association in the interval between the annual meetings, and shall render a report of its actions to the Second General Session.

Invitations for the next annual meeting of the Florida Medical Association shall be presented to the Executive Committee (or Board of Governors) prior to or at the pre-convention meeting. This Committee shall investigate the facilities for entertaining the Association and the feasibility of holding the annual meeting in such places, and recommend the place most desirable, at that time, to the House of Delegates at its first regular meeting, for approval. In the event there is no invitation, the Executive Committee shall recommend the place most desirable.

Sec. 3. The Committee on Scientific Work shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years and thereafter they shall be appointed for three years as the terms expire. The President shall select the Chairman of this Committee. It shall determine the character and scope of the scientific proceedings of the Association, subject to the provisions in the Constitution and By-Laws. It shall prepare and issue a program for each Annual Meeting, announcing the order in which papers, discussions, and other business shall be presented. The number of papers to be read before each Annual Meeting shall be left to the discretion of the Committee on Scientific Work, but no member shall be permitted to present a paper in successive years.

Sec. 4. The Committee on Legislation and Public Policy shall consist of the President and Secretary, *ex-officio,* and six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years and thereafter, they shall be appointed for three years as the terms expire. The President shall select the Chairman of this Committee. Under the direction of the House of Delegates, it shall represent the Association in securing and enforcing legislation in the interest of public health and scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall use every organized influence of the profession to promote the general influence in local, state, and national affairs and elections. Its work shall be done with the dignity becoming a great profession, and with that wisdom which will make effective its powers and influence. It shall have the authority to be heard before the entire Association upon questions of great concern at such time as may be arranged during the Annual Meeting.

Sec. 5. The Committee on Publication shall consist of the Editor and two others to be appointed by the President, and shall have referred to it all reports on scientific subjects and all scientific papers and discussions heard before the Association. It shall be empowered to curtail or abstract papers and discussions, and any paper referred to it which may not be suitable for publication may be returned to the author. All papers read before the Association shall be the property of the Association. The Editor shall receive an annual salary of $600.00, provided that this be paid out of the funds of The Journal.

Sec. 6. The Committee on Medical Education and Hospitals shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. The President shall select the Chairman of this Committee. This Committee shall serve in this State for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

Sec. 7. The Committee on Public Relations shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. The President shall select the Chairman of this Committee. The duties of this Committee shall be to promote friendly relations between this Association and the public, to encourage the propagation of proper medical information to the public, either by publication, radio broadcasts, or talks before community gatherings, the same being censored or controlled by the Florida Medical Association or its component societies.

Sec. 8. The Committee on Necrology shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. The President shall select the Chairman of this Committee. This Committee shall see that a record and biographical sketch of all deceased members is properly recorded in the annals of the Florida Medical Association, and that suitable resolutions are published in its Journal.

Sec. 9. The Committee on Medical Postgraduate Course shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members, two for one year, two for two years, and two

for three years, and thereinafter they shall be appointed for three years as the terms expire. The President shall select the Chairman of this Committee. This Committee shall confer with the officers of the University of Florida and arrange the schedule of a one week's Postgraduate course, to be held annually at the University of Florida at Gainesville. It shall have the power to select the faculty from outstanding medical educators in the United States and make other arrangements necessary for its proper conduction, such as the time, various courses, and the fees to be charged.

Sec. 10. The Committee on Cancer Control shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. The President shall select the Chairman of this Committee. This Committee shall cooperate with the Dr. John Gorrie Memorial Foundation and the Council on Cancer Control of the American Medical Association.

Sec. 11. The Committee on Medical Economics shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. The President shall select the Chairman of this Committee. This Committee shall obtain all information relative to medical economic conditions in this State in general.

Sec. 12. The Committee on Inter-relationship shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. The President shall select the Chairman of this Committee. This Committee shall work with like committees from allied professions—as dentists, pharmacists, and nurses—to provide a medium for discussing and taking concerted action on matters of common interest to these allied professions.

Sec. 13. The Committee on Tuberculosis and Public Health shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. The President shall select the Chairman of this Committee. This Committee shall cooperate with the Florida Tuberculosis and Health Association.

Sec. 14. The Committee on Florida State Medical Institutions shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. The President shall select the Chairman of this Committee. This Committee shall investigate the medical personnel and the medical requirements of all State or public institutions and recommend such changes and improvements as they deem necessary for the most efficient operation of such institutions.

Sec. 15. The Committee on Maternal Welfare shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. The President shall select the Chairman of this Committee. This Committee shall hold joint meetings with the Committee on Child Health and the two, jointly, shall function as the Committee on Maternal Welfare and Child Health. The chairman of this committee shall be chairman of the joint committee.

Sec. 16. The Committee on Child Health shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years and two for three years, and thereinafter they shall be appointed for three years, as the terms expire. The chairman of this committee shall be appointed by the President. The duties of this committee shall be such as usually fall upon such a committee. This committee shall hold joint meetings with the Committee on Maternal Welfare, and the two, jointly, shall function as the Committee on Maternal Welfare and Child Health. The chairman of the Maternal Welfare Committee shall be chairman of the joint Committee.

Sec. 17. The Advisory Committee to the Woman's Auxiliary shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. The President shall select the Chairman of this Committee. This Committee shall advise the Woman's Auxiliary on medical and ethical subjects pertaining to their activities.

Sec. 18. The Committee as Representatives to the Industrial Council shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years and two for three years and thereinafter they shall be appointed for three years, as the terms expire. The Chairman of this Committee shall be selected by the President. The duties of this Committee shall be to represent the Florida Medical Association at meetings of the Industrial Council.

Sec. 19. The Committee on Venereal Disease Control shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years and two for three years and thereinafter they shall be appointed for three years as the terms expire. The Chairman of this Committee shall be selected by the President. The duties of this Committee shall be such as usually fall upon such a committee.

Sec. 20. The Committee on Arrangements shall consist of the component society in the territory in which the Annual Meeting is to be held. It shall, by committees of its own selection, provide suitable accommodations for the meeting-places of the Association and of the House of Delegates, and of their respective committees, and shall have general charge of all the arrangements. Its Chairman shall report an outline of the arrangements to the Secretary for publication in the program, and shall make additional announcements during the meeting as occasion may require.

Sec. 21. Each Committee shall have a report of its activities to submit to the annual Pre-Convention Meeting, and shall make its final report to the House of Delegates at its first annual session. All reports of committees named in this chapter must be approved by the House of Delegates.

CHAPTER VIII

Assessments and Expenditures

Section 1. An assessment of $10.00 per capita on the membership of the component societies is hereby made the annual dues of the Association; of this amount $2.50 shall be set up as an Emergency Fund, and $3.00 shall be considered as a subscription for The Journal. The Secretary of each county society shall forward its assessment, together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county, to the Secretary of this Association thirty days in advance of each Annual Meeting.

Sec. 2. Any county society which fails to pay its assessment, or make the reports required, on or before the date above stated, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 3. All motions or resolutions appropriating money shall specify a definite amount, or so much thereof as may be necessary for the purpose indicated, and must be approved by the House of Delegates on a call of the ayes and naes.

Sec. 4. Any county society shall have authority to remit the dues of its Secretary, to the State Association, for duties performed in accordance with the Constitution and By-Laws.

Chapter IX
Rules of Conduct

The principles set forth in the Code of Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

RESOLUTION

Whereas, The rules of conduct as set forth in Chapter IX of the Florida Medical Association, Incorporated, are: "The principles set forth in the Code of Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public," and,

Whereas, There have sprung up among us various mutual aid societies which render or promise to render medical service for a specified sum, and,

Whereas, These societies actively solicit patients and hire physicians at a fixed rate per month or per patient and thus prevent the free choice of a physician by their clientele, and,

Whereas, This practice is a direct violation of the principles laid down in the Code of Ethics of the American Medical Association, and,

Whereas, This practice constitutes unfair competition and is detrimental to the progress of medical science:

Therefore, Be It Resolved:

1. That the poverty of a patient and the mutual professional obligation of physicians should command the gratuitous services of a physician. But endowed institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, have no claim upon physicians for unremunerated services.
2. That it is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession. By the term "contract practice" as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, principals or agents, and a corporation, organization or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or a fixed rate per capita. Specifically, contract practice is unethical: (1) When there is solicitation of patients, directly or indirectly. (2) When there is underbidding to secure the contract. (3) When the compensation is inadequate to assure good medical service. (4) When there is interference with reasonable competition in a community. (5) When free choice of a physician is prevented. (6) When the conditions of employment make it impossible to render adequate service to the patients. (7) When the contract because of any of its provisions or practical results is contrary to sound public policy.
3. That when a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unethical to give or to receive a commission by whatever term it may be called or under any guise or pretext whatsoever.
4. That it is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy. It is specifically understood that this does not apply to interns devoting their full time to hospital practice.

Be It Further Resolved: That any member violating any of the provisions of this resolution shall be reported to the Executive Committee of the Florida Medical Association, Inc. It shall be the duty of the Executive Committee to investigate such charges and hear the defense of the members so charged. If the charges be sustained, the Executive Committee shall then recommend to the component medical society of which the charged physician is a member such disciplinary measures as are provided in the By-Laws of the component medical society. If further action seems necessary the Executive Committee has the power to report its recommendations to the House of Delegates of the Florida Medical Association, Inc., for such further disciplinary measures as are provided in the Constitution and By-Laws of the Florida Medical Association, Inc.

Be It Further Resolved: That upon the passage of this resolution it shall immediately become a part of the By-Laws of the Florida Medical Association, Incorporated.

Chapter X
Rules of Order

The deliberations of this Association shall be governed by parliamentary usage as contained in Roberts' Rules of Order, unless otherwise determined by a vote of its respective bodies.

Chapter XI
County Societies

Section 1. All county societies now in affiliation with this Association or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws, shall, upon application to the Council, receive a charter from and become a component part of this Association.

Sec. 2. As rapidly as can be done after the adoption of this Constitution and By-Laws, a medical society shall be organized in every county in the State in which no component society exists, and charters shall be issued thereto.

Sec. 3. Charters shall be issued only upon the approval of the House of Delegates and shall be signed by the President and Secretary of this Association. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or the spirit of this Constitution and these By-Laws.

Sec. 4. Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the District if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 5. Each county society shall judge of the qualification of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable white and legally registered physician who is practicing, or who will agree to practice, non-sectarian medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every such physician in the county to become a member.

Sec. 6. Any physician who may feel aggrieved by the action of the society of his county in refusing him membership or in suspending or expelling him, shall have the right of appeal to the Council which, upon a majority vote, may permit him to become a member of an adjacent county society.

Sec. 7. In hearing appeals, the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a Board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 8. When a member in good standing in a component society moves to another county in this State, his name, upon request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves.

Sec. 9. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Sec. 10. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Sec. 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official position and other preferments shall be unstintingly given to such members.

Sec. 12. At the time of the annual election of officers each county society shall elect a delegate or delegates to represent it in the House of Delegates of this Association, in the proportion of one delegate to each twenty members or major fraction thereof, and the Secretary of the society shall send a list of such delegates to the Secretary of this Association, at least ten days before the Annual Meeting.

Sec. 13. The Secretary of each county society shall keep a roster of its members, and a list of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information, upon blanks supplied him for the purpose, to the Secretary of this Association, thirty days in advance of each Annual Meeting, and at the same time that the dues accruing from the annual assessment are sent in. In keeping such roster the Secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

CHAPTER XII.
Amendments

These By-Laws may be amended at any Annual Meeting by a majority vote of all the Delegates present at that meeting after the amendment has laid upon the table for one day.

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TO THE

FLORIDA MEDICAL ASSOCIATION, INC.

State Editor

MRS. A. K. WILSON
4437 Herschell St.,
Jacksonville

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A LETTER FROM THE F. M. A. PRESIDENT

Dear Auxiliary Members:

The Woman's Auxiliary to the American Medical Association has made itself very definitely known in parts of the United States. We feel that the Florida Auxiliary has not ceased to grow and in handing you the following charges for the coming year, I trust that they will, by unifying your work, enable you to continue your growth.

A new charge, and the one activity to be stressed this year, concerns an all-day health institute. The possibilities of distributing health information at this all-day meeting are large and the success with which it meets will depend upon the enthusiasm with which it is put on.

CHARGES

1. Health Institute: To be an all-day meeting of all women's organizations of the county, where numerous short talks on different health topics are to be given by recognized authorities. Further specific suggestions may be obtained from your president or program chairman.

2. Cooperate with the cancer program, under the direction of Mrs. Ralston Wells.

3. Allow two minutes at each meeting for the presentation of Hygeia information.

4. Endeavor to see that the American Medical Association broadcasts of health dramas are secured by your station.

5. Urge attendance at the State and National Conventions.

Wishing for you a very successful year, I am

Very respectfully,
EDWARD JELKS, M. D., *President*
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★*Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245* ☐
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154 ☐
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11 ☐
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60 ☐

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SOUTHERN NEWS

A communication from the Woman's Auxiliary to the Southern Medical Association reminds us of the next meeting, New Orleans, La., from November 30 to December 3, 1937. The two major projects of the Southern Auxiliary are the Jane Todd Crawford Memorial, with Mrs. T. R. Wilson, Greenville, S. C., as chairman, and the Research and Romance of Medicine under the direction of Mrs. S. A. Collom, Sr., of Texarkana, Tex. Under the latter a loan library is maintained, from which health programs, prepared talks and pamphlets may be secured by Auxiliary members.

* * *

DUVAL COUNTY

The October meeting of the Woman's Auxiliary to the Duval County Medical Society was held in the home of Mrs. O. P. Broadbent. Hostesses for the afternoon with Mrs. Broadbent were: Mrs. J. W. Hayes and Mrs. Victor A. Hughes. Twenty-four members attended.

The meeting was opened by the President, Mrs. John H. Owens. Much interest was shown concerning plans for the health institute to be held this Spring under the direction of Public Relations Chairman, Mrs. E. W. Veal. It was announced that time had been secured for the broadcast of the A. M. A. health dramas over station WJAX. Mrs. F. W. Krueger, program chairman, introduced the speaker of the afternoon, the Rev. L. F. Marsh who spoke on "A Changing India," discussing India's health problems from his missionary experience. Each member was presented with a pocket-size booklet containing the Constitution and By-Laws of the County Auxiliary, and a supplementary folder containing names of officers and special committees for 1937-38, together with the time, place and program for the quarterly meetings.

* * *

POLK COUNTY

Mrs. S. M. Copeland of Jacksonville, state president of the Auxiliary to the Florida Medical Association, spoke at the October dinner meeting of the Polk County Auxiliary, outlining the work for the coming year.

Mrs. Copeland laid particular stress on the cancer control program and the health drama broadcasts sponsored by the American Medical Association. Dedicated to school children,

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these programs are to be broadcast on Wednesday afternoons from 2 to 2:30, beginning October 27 and continuing through June 15. Mrs. Copeland expressed the hope that radios would be made available to all schools.

Following the dinner a Holloween program of games was enjoyed, and Mrs. J. D. Griffin entertained with musical selections. On the entertainment committe were: Mrs. J. W. Vaughn, Mrs. Joe M. Bosworth, Mrs. T. H. Roberts. Twenty-two members attended.

ADVERTISERS' NOTES

ARSENIC EATING

The peasants of Styria, a mountainous Austrian province, indulge in the strange practice of arsenic eating. Styrian spring waters and the soil itself are purposely ingested in quantities which are said to contain as much as eight grains of the drug, and such doses are often taken several times each week. One who is acquainted with the action of arsenic would expect severe poisoning to result, but on the contrary the arsenic eaters apparently derive a tonic effect.

The physician who prescribes arsenic cannot be so oblivious to its toxicity but, fortunately, the drug in certain newer compounds may be administered with little danger of intolerance. Carbarsone, Lilly, is such a preparation which during its broad acceptance as an amebicide has been unusually free of toxic properties.

* * *

HENRY KENDALL MULFORD

America lost one of its foremost exponents of preventive medicine in the passing of Henry Kendall Mulford, in his 71st year, on October 15, 1937.

The company which bore Mr. Mulford's name was the first in this country to commercially distribute antitoxins. Smallpox vaccine and curative serums used in the prevention and cure of infectious and contagious diseases were soon added. Through the distribution of these biologicals, he was probably responsible for the saving of more lives than any other man in the history of medicine and pharmacy. These alone stand as a fitting monument to his life of service to humanity and, thanks to his stimulating influence on the younger men whom he drew around him, the good work that he accomplished and new work started will continue to grow on and on.

The story of the life of Mr. Mulford, as unfolded by men who have known him since his embarkation into the field of pharmacy, is of interest. Born in Bridgeton, New Jersey, October 10, 1866, of old New England stock, H. K. Mulford came from a family of sea captains, and his forebears played an important part in local history. He attended the Bridgeton elementary school, later the South Jersey Institute, a military prep school having a curriculum comparable with present college work.

The degree of Master of Science was conferred upon Mr. Mulford by Lafayette College in 1918, and the highest honor in pharmacy, Master of Pharmacy, was conferred upon him by his Alma Mater, the Philadelphia College of Pharmacy and Science, in 1933. He was a member of the American Pharmaceutical Association, American Drug Manufacturers' Association, American Pharmaceutical Manufacturers' Association, American Chemical Society, the Franklin Institute and the Union League.

The drug world, educators and publishers deeply mourn the death of H. K. Mulford, an inspirational leader; an indefatigable worker; a man among men; unimpeachable in character and integrity; a loving husband, father and grandfather; a man loved and beloved by all who knew him, and his friends were legion.

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Winter is a jailer who shuts us all in from the fullest vitamin D value of sunlight. The baby becomes virtually a prisoner, in several senses: First of all, meteorologic observations prove that winter sunshine in most sections of the country averages 10 to 50 per cent less than summer sunshine. Secondly, the quality of the available sunshine is inferior due to the shorter distance of the sun from the earth altering the angle of the sun's rays. Again, the hour of the day has an important bearing: At 8:30 A. M. there is an average loss of over 31 per cent, and at 3:30 P. M., over 21 per cent.

Furthermore, at this season, the mother is likely to bundle her baby to keep it warm, shutting out the sun from Baby's skin; and in turning the carriage away from the wind, she may also turn the child's face away from the sun.

Moreover, as Dr. Alfred F. Hess has pointed out, "it has never been determined whether the skin of individuals varies in its content of ergosterol" (synthesized by the sun's rays into vitamin D) "or, again, whether this factor is equally distributed throughout the surface of the body."

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BOOKS RECEIVED

Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.

TWENTY-FIVE YEARS OF HEALTH PROGRESS. *By* LOUIS I. DUBLIN, Ph.D., Third Vice-President and Statistician, and ALFRED J. LOTKA, D. Sc., Assistant Statistician, Metropolitan Life Insurance Company. A volume "addressed to health officers, physicians, sociologists, life insurance officials, and others interested in the health and welfare of the wage earning population." This comprehensive work, profusely illustrated by charts and tables, covers in twelve chapters and two appendices: An Era of Health Progress; The General Mortality from All Causes; The Trend of Longevity Through a Quarter Century; The Principal Communicable Diseases of Childhood; Tuberculosis; Influenza and Pneumonia: Cancer; The Principal Cardiovascular-Renal Diseases; Diabetes Mellitus; Diseases of the Puerperal State; Miscellaneous Diseases of Special Interest; External Causes of Death; Methods of Compilation and Analysis of Data; and Tables of Mortality Experience of the Industrial Department of the Metropolitan Life Insurance Company. Cloth. Published in limited edition for distribution of complimentary copies to a selected list of libraries and specialists in public health and allied fields. Pp. 611. Metropolitan Life Insurance Company, New York.



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1a. 1934. J. Amer. Med. Assn. 102, 892.
b. 1936. Ibid. 106, 996.
c. 1937. Ibid. 108, 7 and 15
d. 1937. Ibid. 109, 756.
2. 1931. J. Nutrition 4, 267
1932. Ind. Eng. Chem. 24, 650.
1933. J. Amer. Diet. Assn. 9, 295.
1935. Amer. J. Public Health 25, 1340.

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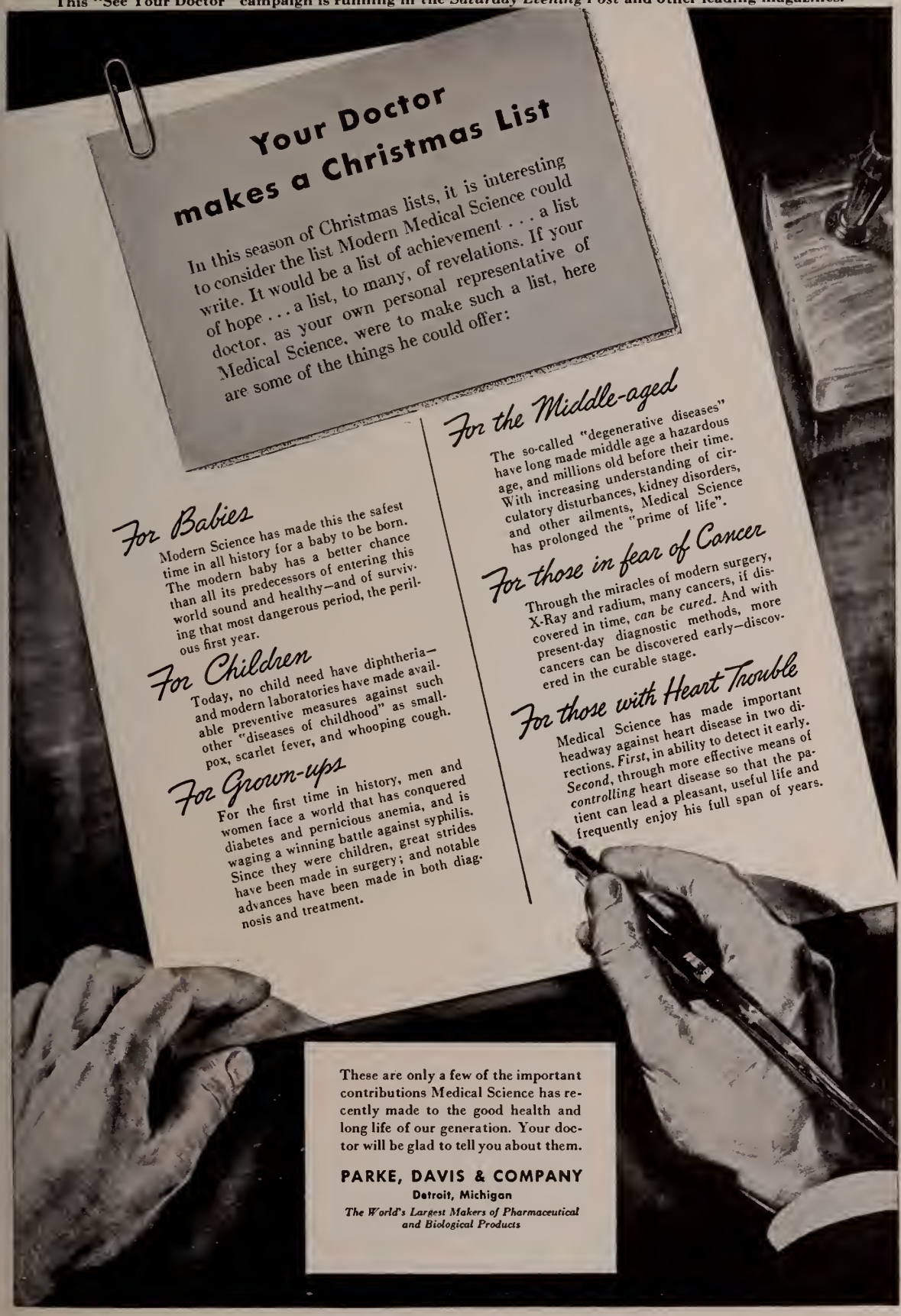
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CARCINOMA OF THE BODY OF THE UTERUS*

CAYETANO PANETTIERE, M.D.,
Miami Beach

Admittedly the best results obtained in the treatment of cancer anywhere in the body lie in the early recognition of the disease. Since bleeding is the one outstanding symptom of cancer of the uterus, and since this disease is most prevalent at the time of the menopause, irregular bleeding occurring at that time may be interpreted by the patient as nothing abnormal and may even be passed up without further concern. The transition from a normal menstrual flow to a pathological bleeding is gradual. We are often impressed with the seeming disregard with which women interpret abnormal bleeding, particularly at the menopause. Many women believe that the menopause is associated with increased bleeding or more often that increased bleeding foreshadows the menopause. In cancer of the uterus, the periods may be increased in duration, increased in volume, or increased in frequency. Since each patient presents a menstrual history characteristic to herself, any deviation from her personal routine should be studied and no abnormal bleeding should ever be permitted to continue unexplained. Leukorrheal discharge may or may not be associated with metrorrhagia. When present, it is usually serosanguineous, but scant at the onset. Later the discharge becomes foul, profuse and irritating. Pain is usually present only in advanced cases and is reflected by the areas involved.

FREQUENCY

While cancer of the body of the uterus is not as frequent as cervical carcinoma, it is by no means a rare disease. Cancer of the uterus is responsible for 25 per cent of the deaths from cancer from all causes in women; and 10 per cent of uterine cancers occur in the corpus.

According to Ward, the average duration of life in untreated cases is from twenty to twenty-four months from the onset of symptoms. Carcinoma of the uterus is almost always primary. It appears in women of ages varying from twenty to seventy-nine. The disease is encountered more often after the menopause and its average age-incidence is about eight years later than in those patients suffering with carcinoma of the cervix. It bears no relationship to childbirth, the incidence being about equal for nulliparous as for multiparous women and while the disease is more prevalent after the menopause, it is present in 30 per cent before the climacteric. While pregnancy is not considered a factor in the production of uterine carcinoma, it is sometimes associated with it; the incidence being estimated at about .05 per cent. Uterine myomata are frequently associated with carcinoma of the fundus of the uterus; various observers report 35 per cent of their series of cancer of the body of the uterus associated with myomata.

INVASION

Invasion is chiefly by extension. The tumor remains restricted to the uterus for a long time, as is evidenced by the large percentage of cures following operative procedures. As the growth develops, it makes its appearance under the peritoneum, and laterally through the tubes, ovaries and parametria; or it may proceed directly between the folds of the broad ligament. Distant metastases are late and infrequent.

PATHOLOGY

Early fundal carcinoma is almost always confined to the cavity of the uterus where it starts from the surface epithelium of the glands of the endometrium. It is for this reason that curettement renders the diagnosis of carcinoma of the body practically certain. The tissue curetted should be sufficient to render enough material for a satisfactory frozen section. Negative reports from frozen sections need not necessarily mean that the patient does not have carcinoma. In those cases where the frozen section examination is either negative or unsatisfactory, a permanent paraffin section should be made. The paraffin sections should be taken from different levels, in

*Read before the Sixty-fourth Annual Meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, 1937.

order that no part of the tissue is overlooked. The microscopic diagnosis from the tissue removed by curettement is usually correct. Reports from the various clinics prove this to be the fact. This fact, however, is usually true only when the pathologist is a student of considerable experience and can make a diagnosis even on border-line cases. Inexperienced pathologists render the field of surgery particularly hazardous, and it is better to have no report at all than to have an incorrect one. The gross pathology in cancer of the uterus may be said to be a rather advanced stage of the disease. The earliest manifestations of the disease are, of course, microscopic and these may appear either as the primary manifestations of carcinoma or with associated lesions like fibromyoma of the uterus. When the condition is associated with myomata, the diagnosis is apt to be delayed.

Since the outstanding symptom of carcinoma of the uterus is bleeding and since bleeding is also a manifestation of fibroid disease, the presence of one or more fibroids may for the time being explain the bleeding and therefore delay treatment. Many times at operation a uterus which has been removed for a fibroid disease proves after opening the uterine cavity to be a carcinoma. It is an important step in pelvic surgery that no abdomen should be closed after a hysterectomy performed for a fibroid uterus until after a complete examination of the specimen including the uterine cavity has been made immediately after its removal. Histologically, cancer of the fundus is usually of the adenocarcinomatous type. Sarcomatous degeneration of fibroids are so rare that for ordinary purposes they need not be considered. Various authors vary their estimates as to the frequency, but the concensus of opinion is that they vary in the ratio of sixty to one; that is, sixty cases of carcinoma to one of sarcoma.

TREATMENT

The treatment of carcinoma of the body of the uterus is by: (1) surgery; (2) irradiation; and, (3) a combination of both. It is the concensus of opinion that for those cases where the growth is localized and where no evidence of invasion is present, that the treatment par-excellence is radical surgical removal. This group of cases gives perhaps the most favorable prognosis and the largest number of permanent cures. As stated above, carcinoma of the uterus remains localized for a longer period and metastasizes later than cervical carcinomas; and for this reason permanent cures are greater than with carcinoma of the cervix.

A review of the literature for the past ten years shows a definite trend towards radiation of malignant tumors of the uterus, regardless of whether they be cervical or fundal. While radiation of the fundus for carcinoma has most excellent exponents, there is manifestly a preponderance of opinion that radical surgical removal represents a greater percentage of five-year cures from the standpoint of the general operator. The initial mortality is relatively low, the morbidity about equal, and the percentage of cures greater than in those cases where radium alone has been used. One must remember that the application of radium in the fundus is a blind procedure, that it is associated with numerous complications, and that the morbidity is greater than with surgery. Davis, in a brief report from the Massachusetts General Hospital, reviews fifty cases of adenocarcinoma of the uterus treated by surgery, and found 60 per cent five-year cures and adds that "this compares favorably with the results of the treatment of cancer anywhere in the body, excepting only superficial lesions of the skin." However, in those patients who are poor operative risks, due to senility, obesity, cardiovascular disease, renal insufficiency or diabetes, surgery should not be resorted to, for then the initial mortality would be great. Radium here offers by far the most promising end-result.

Some clinics report 43.5 per cent cures with radium alone. Norris and Dunne, in a recent survey, report 44.5 per cent five-year cures. Kelly is still in favor of the radical surgical removal of fundal carcinoma followed by radiation.

It will be noticed, therefore, that there is no unanimity of opinion at present as to what constitutes the ideal treatment for adenocarcinoma of the body of the uterus. There are those who advocate surgery alone, those who advocate radium alone, those who prefer hysterectomy followed by irradiation, and those who believe in preoperative irradiation with subsequent hysterectomy. Again, the radiologists are not uniformly agreed—one group prefers to give large doses in a short time,

that is, in one or two sittings, and the other group prefers to give small doses over a fairly long period of time.

We, as gynecologists in this country, prefer the supravaginal route. A panhysterectomy is performed, removing the tubes and ovaries. European surgeons, particularly the Austrians and Germans, prefer the vaginal route and report most excellent results. Stoeckel reports 59.8 per cent five-year cures by the vaginal route.

It is therefore too early in the present management of this disease to say just where the ideal method of treatment lies. We agree that surgery offers the most favorable prognosis in uncomplicated cases, that in advanced cases preliminary radiation makes the patient more operable and decreases the possibility of dissemination, and that x-radiation following operation improves but little the chances for ultimate cure. Of this we are certain—even with a modest claim for 50 per cent five-year cures no treatment for internal carcinoma presents a better expectation of success than that achieved in the treatment of carcinoma of the body of the uterus.

P. O. Box 227.

DISCUSSION

Dr. H. C. Dozier, Ocala:

Dr. Panettiere has presented a very clear, concise and orderly paper on a subject of tremendous importance to the menopausal and post-menopausal woman, and to those of us who have to deal with such conditions in our practice. There is little that I can add.

The patient can be benefited with any degree of certainty only if the diagnosis is made early. The diagnosis can be made early only through a painstaking education of the laity in the recognition of certain early symptoms and signs which may mean carcinoma, and then an energetic and careful investigation by the physician or surgeon of any unusual vaginal bleeding at the time or following the period of the woman's "change of life."

If there is post-menopausal bleeding, of course, the first thought is that of malignancy. However, let us remember that bleeding may be caused by benign lesions also, and may not always come from the uterus since malignant growths, associated with bleeding, may affect any part of the reproductive tract, from the vulva to the ovaries.

As a rule a careful examination will reveal the location, or source, of the bleeding and also whether it comes from benign or malignant lesions. In such an examination we should look for abrasions of the vulva, cancer of the clitoris, which is practically hopeless, a traumatised everted or prolapsed urethral mucosa or a urethral caruncle.

Careful examination of the cervix is next in order. If this is negative, next determine whether the bloody discharge is coming out of the cervical canal. If it is, there is some growth or disease of the fundus or adnexa. If the fundus is enlarged and the adnexa are negative to examination, a careful curettement should be done and the tissue scrapings examined by a competent pathologist. If the fundus is normal, and there is a palpable mass of either tube or ovary, then the curettement should still be done, and if the scrapings are negative for malignancy, then an exploratory laparotomy is indicated.

Before an operation for definite malignancy which is considered operable, I believe preliminary x-radiation should be given.

I wish to congratulate Dr. Panettiere on his clear, concise presentation of this subject and thank him for the privilege of discussing it.

Dr. Gerry R. Holden, Jacksonville:

Dr. Panettiere has touched the high lights of this subject very completely. I feel that he is much to be congratulated.

There are, perhaps, a few minor points that might be mentioned. I would like especially to comment on the value of the history, not only in cases of fundal carcinoma, but also in all cases of uterine hemorrhage. We have so many physical aids in diagnosis today that I feel we often minimize the value of the history. It can be helpful in all cases where the diagnosis is not plain and it is always most interesting to try to figure out what lesion is present before you make the physical examination.

The age of the patient is significant. In women under 45 the majority of all cases of vaginal hemorrhage are of benign origin. In women past the menopause many, and probably the majority, of such cases are caused by malignancy. Especially significant is bleeding in older women, 50 or over. In them the most frequent lesion is cancer of the fundus.

The character of the bleeding is significant. Profuse hemorrhages are more frequent in cervical cancer. In fundal cancer not only are the women older, but the hemorrhage is less, more apt to be prolonged over a greater period of time.

The treatment of fundal cancer differs, theoretically at least, from that of cervical cancer. Since the fundus type grows more slowly, metastasizes later and, most important, is more resistant to radiation than is the cervical type, hysterectomy, either with or without radiation, is the preferred method of treatment. However, we must realize that many of these women are poor surgical risks. In such cases radiation is often better. Probably the best results in treatment of fundus cancer have been reported by Healy of the Memorial Hospital, New York.

Radiation treatment of cancer of the fundus is often disappointing. As Dr. Sams reports in some of the dermatologists' treatments, the first few years that he is using such treatment he will be much encouraged. Later on he becomes less enthusiastic. Recurrences in cervical cancer after five years are very few. Unfortunately in fundal cancer we may have them after many years of apparently perfect health.

I want to thank Dr. Panettiere for this opportunity of discussing his most interesting paper.

Dr. Gerard Raap, Miami:

I should like first of all to compliment the rather broad viewpoint that has been taken in this paper. I should like to exercise my prerogative as a radiologist to bring up one or two points with reference to the matter of diagnosis. It seems to me that in the discussion thus far, there is one point that has not been mentioned and that is the frequency with which the local signs of a carcinoma of the body of the uterus are not evident, but in which we do find that the first signs are an extensive form of invasion, or of metastasis. This has occurred in my observation with sufficient frequency so that I feel we should not rest our diagnosis entirely on local signs. In that woman who develops pain and whose age period coincides with that of carcinoma of the body of the uterus, x-ray examination of the long bones, lumbar spine, and the skull should be made to rule out the possibility of metastases. In some instances these changes may be very slight, but they are usually quite pathognomonic when due to a primary focus in the body of the uterus.

The second point is this. Fairly positive statements have been made as to the relative value of radiology and surgery in these cases. The general concensus has always been that the surgical method is the method of choice, at least in the confined type or early case, and since we do not know what the extent of invasion or metastasis of these lesions may be, we must be particularly careful as to how we classify these cases as to fitness for operation. Our judgment must be based upon the patient and the local condition. The statistics quoted are based upon operable cases, or technically operative cases. The radiologist must base his statistics on both the operable and inoperable, and that difference in predication of these statistics must always be borne in mind.

Dr. Cayetano Panettiere, (Concluding):

I certainly wish to thank the discussors for their very excellent remarks. I think we are all pretty well agreed that the essential point in carcinoma of the body of the uterus is early diagnosis. If we see and diagnose our cases early and if our patients come to us early for treatment, whether it be radical removal or radiological, our present percentage of cures will be greatly increased.

BREAST FEEDING WITH ESPECIAL REFERENCE TO SOME OF ITS PROBLEMS*

LUDO VON MEYSENBUG, M.D.,
Daytona Beach.

It should be unnecessary to remind any medical audience of today that the ideal food for the baby is its own mother's milk, and yet there is certainly an increasing tendency, not only on the part of the laity but of the medical profession as well, to underestimate the importance of breast feeding and to overemphasize the artificial food. As an illustration of this tendency, witness the myriad numbers of baby foods on the market today.

Perhaps our present day knowledge of nutrition and of infant feeding, as compared

*Read before the Florida East Coast Medical Assn., Ft. Pierce, Nov 13, 14, 1936.

with that of two decades ago, are responsible for the failure of most mothers to nurse their babies; for in our larger cities the stress and strain of social life make nursing an increased burden that few women are willing to carry; their consciences are at rest if their babies "do well' on the bottle. Little do these mothers realize that they are robbing their infants of their birthright, or, if they do realize it, they do not deserve the blessing of having children.

But the mothers are not alone at fault. There are many of our medical colleagues who specialize in weaning babies and writing formulae. Whether they do this to increase their work or whether they sincerely believe that that bottle is better than the breast, I do not know. Such physicians, in any case, are spreading a false doctrine and, to my mind, are guilty of malpractice every time they wean a baby without sufficient reason. On the other hand, those of us who conscientiously insist on breast feeding, have been called "old fashioned" by the modern young mothers, who simply don't want to be bothered with nursing their babies. Allow me to quote to you a paragraph from one of Oliver Wendell Holmes' "Medical Essays":

"We are willing to give Liebig's artificial milk when we cannot do better, but we watch the child anxiously whose wet-nurse is a chemist's pipkin. A pair of substantial mammary glands has the advantage over the two hemispheres of the most learned professor's brain in the art of compounding a nutritious fluid for infants." This was written in 1867 and is just as true today as it was then.

Taking up the subject of nursing, there are many practical points that I wish to emphasize and problems that confront us for discussion.

It is my custom to put the newborn babe to the breast 12 hours after birth, allowing it to nurse one breast for five minutes, every four hours. The breasts are alternated. Until the milk flow begins, generally on the third or fourth post-partum day, two ounces of 5% lactose solution, to which are added 5 grains of sodium citrate, are given every four hours in order to prevent too great a loss of weight, and the rise in temperature that we recognize as inanition fever.

When the milk flow is established, the baby is put to the breast every 2½ or 3 hours and allowed to nurse for twenty minutes. The mother must be impressed with the importance of regularity in nursing, waking the baby when the hour is at hand and keeping it awake while at the breast, not always an easy task. A night nursing, after 10 p. m., is to be avoided from the start, if possible; but in my experience the majority of young babies, especially if smaller than the average, will not go through the night until 6 a. m., without demanding food. In such instances a 2 a. m. nursing is allowed, and I have found that after from four to six weeks the baby will break itself of this nursing and sleep through the night, provided it has received enough during the day.

It is during the early weeks after birth that some of our most disconcerting breast feeding problems arise. The first is the case of the baby born in the hospital and kept in the nursery out of earshot of the mother. If the baby cries during the night she does not hear it. The nurse offers lactose solution, and the baby goes back to sleep. The first night at home the baby is apt to be even more wakeful and to do a good deal of serenading during the small hours. This brings a call for the doctor and it is at this time that it is wise to allow the 2 a. m. nursing. This is done not only to quiet the baby but, if the breasts are full and leak easily, they will drench the bed in spite of binders and that much milk is lost to the baby. It will do more good to the baby than to the bed.

Another problem arising during the early weeks is that of the crying, fretful baby who does not sleep enough. Such babies, as a rule, are not getting enough milk and this can be checked by weighing before and after each nursing during a 24 hour period. In order to do this it is necessary to have beam scales graduated in ½ ounces, preferably in ¼ ounces. At two weeks of age a baby should obtain an average of no less than 2½ ounces a feeding.

The baby that spits a good deal or actually vomits causes no little concern. This may be due to an abundance of milk, overloading the stomach, with consequent regurgitation of the overflow. Such a condition results in no harm and it is unwise to cut the nursing time short, for that would deprive the baby of the cream in the strippings and, further, would prevent

thorough emptying of the breasts which is essential in maintaining a good supply of milk. Lengthening the nursing intervals to four hours invariably corrects this type of regurgitation.

When this spitting or vomiting is not due to overfilling, further study of the cause is necessary. It is seldom that the quality of the mother's milk is at fault, though this should be analyzed, especially with reference to the fat content. If this is too high (above 8% cream), a reduction in the fat constituents of the mother's diet, together with drinking more water, will generally effect the desired change in the milk. If it does not, from ½ to 1 ounce of boiled water may be given to the infant just before each nursing, to dilute the milk.

Frequently faulty mechanics of the nursing technic causes the baby to regurgitate. If the baby has been crying a good deal before the nursing, it should be held up and allowed to belch the air swallowed incident to crying. Furthermore, interrupting the nursing and giving the infant an opportunity to raise air swallowed while nursing, as well as after, will prevent collection of air in the stomach with consequent discomfort, crying, spitting or even vomiting.

The symptoms of pylorospasm and of hypertrophic pyloric stenosis usually begin in the second week of life and these conditions require careful study and analysis. Wherever projectile vomiting is encountered, together with failure to gain, or weight loss, in a constipated baby, visible gastric peristalsis and pyloric tumor must be sought. In pylorospasm atropin, in doses of gr. 1:1000 to 1:500 by mouth, before each nursing, is specific while stenosis should be given the benefit of an immediate Fredet-Rammstedt operation as soon as the diagnosis is made. Although operative interference is my choice in the handling of these cases, I am fully cognizant that medical treatment has its ardent advocates.

Whereas it is not the purpose of this paper to discuss pyloric stenosis, nevertheless, the subject is too important to pass over without comment. Briefly stated, the medical treatment consists in the use of thick cereal and milk feedings, cooked to a consistency so thick that it will adhere to the inverted spoon. This pap is pushed off the spoon with the tongue blade far back into the baby's mouth, so as to excite the swallowing reflex. The rationale of this method is based on the fact that a thick gruel will stay down when a liquid feeding will not. Atropin may or may not be given, depending on the presence or absence of associated spasm. Naturally, success with this treatment is contingent on the degree of stenosis as determined by fluoroscopic observations and gastric retention studies. If stenosis is extreme, favorable results cannot be expected, valuable time is lost, the baby loses weight rapidly and finally becomes a grave surgical risk.

At best, medical treatment is a long drawn out affair, covering many months, and leaving a weak, anemic, underweight baby. The Rammstedt muscle splitting operation, on the other hand, is simple, requires not more than 15-20 minutes to accomplish, may be performed under local anesthesia, entails little or no shock to the patient and convalescence and weight gain are very rapid.

The simple types of regurgitation and vomiting I first try to relieve by giving a teaspoonful of lime water from a medicine dropper, slowly, into the corner of the baby's mouth, while he is nursing. If the stools are loose and numerous this simple procedure is often specific for both the spitting and the frequent passages. In rare instances I am forced to use atropin, in doses as given for pylorospasm, to relieve regurgitation and vomiting especially if these occur in a hypertonic type of infant. Such infants have a shrill cry which is frequently exercised; their arms and legs are stretched in full extension when awake; they are "jumpy" in sleep and the reflexes are hyperactive. Seldom does atropin fail to relieve the vomiting and spasticity. It gives relaxation, better appetite and quiet sleep.

A more annoying disturbance in the breast fed baby is that resulting from sensitization to some protein in the mother's milk. It has been a pretty general experience that eggs in the mother's diet are the most frequent offenders.

When there is trouble with the baby, I always interdict the eating of eggs. Sea-food, especially shell fish is often responsible for allergic reactions in the baby. However, any type of food, from soup to nuts, may be re-

sponsible and it is necessary in many instances to do skin tests on the baby with the extracts of foods in the mother's dietary. These allergic reactions manifest themselves by true colic, vomiting, diarrhea and eczema. It is my belief that real colic in a nursing baby is due to protein sensitization and can be corrected only by finding the cause and prohibiting the offending food in the mother's diet. Weaning in such cases is not only unnecessary but unjustifiable. The physician who treats babies and is confronted by such a problem must find the offending food, by elimination diets or skin tests if necessary; otherwise he has not done his full duty to his patient.

Nearly every baby, breast or bottle fed, has his "off" days just as we grown-ups have. Fretting, wakefulness, and crying are the result. Some unusual commotion in the house, too many visitors, too much noise may be the cause. The next day brings relief. I recall one baby in a household of grandparents, several aunts, uncles and many young cousins. Noise predominated not only during the day but far into the night. This baby for months slept only about half an hour during the day and not much more at night. It was "on edge" the entire time. Needless to say the baby gained very poorly although receiving an abundance of good breast milk. A study of the home conditions revealed the cause. I finally prevailed on the parents to move. Instant relief resulted.

Constipation in the nursing baby is often troublesome. It may be due to insufficient milk or, in a rapidly gaining baby, to the more complete utilization of an abundant milk supply. High fat or low lactose content of the milk may result in a constipated baby. Local causes, such as anal fissure or tight sphincter ani muscle, must be looked for and, if found, relieved. There is no evidence that constipation is hereditary. The daily use of laxatives, purgatives, or suppositories is to be strongly condemned. They only increase the constipation, are irritants, harmful and habit forming. Plain warm enemata given daily, if necessary, can do no harm and will always give the desired result. If the infant is old enough, roughage in the form of pureed vegetables or finely powdered spinach, available in a preparation called "Spintrate," may be added to the diet and will nearly always relieve the constipation. Tomato juice and pineapple juice are more laxative than orange juice and should be given instead of, or in addition to, orange juice.

Many normal nursing babies have a natural bowel action only every other day without harmful effects; others have from 4 to 6 stools every twenty-four hours and do equally well. Such occurrences in the bottle baby should cause alarm and require correction; in the breast-fed we need pay little or no attention to them.

It has been my practice for many years to give nursing babies one supplementary bottle (dubbed by one of my more intelligent mothers, "consolation bottle") at six weeks of age. At this time the mother's milk has reached its mature state and the baby is still young enough to be indifferent as to whether it gets the breast or the bottle. This one bottle, taking the place of one nursing, gives the mother more time for relaxation and recreation and freedom from the baby which, in turn, increases and betters her milk supply. She is allowed to elect the feeding at which this bottle is to be given but she must continue giving it at that feeding daily. Concomitant with this bottle, orange juice and tomato juice are given and increased at intervals. Viosterol alone or in combination with halibut liver or codliver oil are given throughout the year except during the very hot summer months.

When the baby weighs 16 pounds, cereal in the form of barley jelly, interchanged with strained oatmeal, Mead's cereal, cream of wheat, farina and several others of the special baby cereals, is added and given twice daily, before the 9 a. m. and 6 p. m. nursings. Vegetables are added at about the seventh month, depending on the size of the baby and its need for roughage; beef juice and broth a little later. When baby has a tooth it is allowed to mouth a piece of unsweetened zwieback. Routinely I have, for the past ten years, given mashed ripe banana pap, beginning it as early as the fourth month. In constipated babies and those not gaining satisfactorily it gives excellent results.

When the breast milk supply begins to fail early, as it so often does, it is necessary to help by giving complementary bottles immediately following the breast. At first this is

usually required only after the afternoon nursing but soon invariably after morning feedings as well. At this time efforts should be made to increase the milk output. An abundant diet with a great deal of fluids, malted milks, beer, etc. will help. The greatest good, however, will result from increased stimulation of the breast by manual expression *after* the baby has finished nursing. This insures thorough emptying of the breast and makes an increased demand which is often rewarded by an increase in the supply. I have found very few mothers, however, who were willing to give this additional 5 or 10 minutes to the feeding time and unless complete cooperation is obtained, together with the proper mental attitude of the mother, no results need be expected.

As to causes for weaning, I am inclined to agree with Sedgwick that the only justifiable reason for weaning is active tuberculosis in the mother. Whatever my inclination in this regard may be, I am well aware that there are other imperative reasons from the standpoint of the mother. But I do not hold with those who would wean because of an attack of acute infectious disease, including typhoid fever. I have seen a mother nurse her baby at the breast successfully through an attack of scarlet fever, without transmission to the baby.

Recent studies, based on a large series of cases, seem to show that six months is the best age at which to wean. Bottle babies after that age do as well or better than the breast fed and are no more prone to illness. During the first six months the breast fed babies are far ahead of their bottle brothers. However, as in everything else, common sense must prevail in determining the exact age for it would not do to wean a baby during an acute illness just because he should happen to pass his sixth month while he was sick.

I endeavor to have my feeding patients brought to me once a month for weighing, examination, toxoid administration at the proper time, vaccination against smallpox and additions to the dietary. If the mother is conscientious, results are excellent.

It is my firm conviction that nowhere is the application of common sense more productive of good than in the management and feeding of the little child.

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ACUTE CRANIOCEREBRAL INJURIES*

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Each year the injuries from automobile accidents is increasing. Statistics show that in 1936 there were approximately 36,000 deaths attributable to motor accidents. It is estimated that for each death there are four patients with serious injuries and a large percentage of these have fracture of the skull. Other etiological factors of head injury are blows on the head from falling or from being struck by various objects in fights, and injuries sustained in industrial accidents.

Injuries of the head may involve the scalp, the skull, and the brain with its meninges. Either may be involved without the other and frequently we have a break in the continuity in all of them.

Laceration of the scalp is mentioned because of its importance as a cause of possible intracranial complications. Most of these lacerations are caused by blunt objects and there are ragged and torn edges with devitalized tissue which if sutured without debridement many predispose to infection. Infection of the scalp resulting from a poorly treated lacerated wound may cause osteomyelitis of the skull or even brain abscess. The proper treatment of these lacerations is to shave the scalp for a few inches around the wound, then disinfect the skin about the wound and infiltrate with novocaine. The laceration itself can then be disinfected without pain and the wound debrided by excision of the edges thereby converting it into a clean incised wound. In each case the underlying skull should be thoroughly examined either by direct inspection or with the finger to determine the presence of a fracture or a depression. Too often a laceration of the scalp is sutured without recognizing a depressed fracture of the skull beneath.

The treatment of laceration of the scalp as mentioned is dependent on the patient's general condition. When the patient is first admitted and there is evidence of shock, the debridement should be delayed until there is recovery from shock. It is best that the laceration be treated during the first sixteen hours before the period of infection sets in.

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In contusion of the scalp there may be a large fluctuant swelling due to the accumulation of blood between the scalp and the skull. Pressure of the finger over the center of the swelling may give a sense of depression in the skull, especially when the margin of the hematoma feels roughened due to clots beneath the pericranium. These cases usually require x-ray examination to rule out a depressed fracture. Sometimes the hematomas are extensive and may require aspiration with a large needle, and occasionally a short incision for evacuation of the solid clots.

There are two types of fractures of the skull which we consider of importance from the surgical standpoint; one is compound fracture and the other depressed. All fractures of the skull are of importance because they may disclose the location of the blow and tell us it was a severe one and sufficient to produce damage to the underlying structures. It makes little difference whether the fracture is of the vault or of the base except in the latter the injuries are usually more severe and are more apt to lead to complications because of possible communication with the middle ear or nasal accessory sinus. In compound fracture of the vault no operative treatment is indicated except the proper treatment of the overlying scalp wound as above described.

A depressed fracture of the skull requires operation to remove the continued local pressure on the brain and to repair the damaged dura and brain beneath the fracture. Epilepsy is a frequent complication of untreated depressed fracture of the skull and it is felt that this complication may be lessened by early adequate operative treatment. In compound depressed fracture of the skull it is urgent that the operative treatment be carried out as early as possible after the injury to prevent infection, preferably within the first twelve or sixteen hours. Frequently with these injuries there is laceration of the dura and brain which is always the case in penetrating wounds of the brain. The operative treatment should consist of elevation and removal of the depressed fragments of bone in order to make a thorough examination and cleansing of the brain wound. By irrigation of the wound in the brain with Ringer's solution loose blood clots and fragments of lacerated brain tissue may be washed away. By gentle suction the contused, devitalized edges of the brain wound and the blood clots may be further removed, lessening the chances of infection and subsequent scarring. The dura should be closed tightly and if there is a defect due to loss of tissue a piece of facia may be used to make the repair. Usually the fragments of bone removed can be replaced in the wound to bridge over the defect in the skull. In simple depressed fracture of the skull the danger of infection does not exist and one may delay operating for several days if the patient's condition is not good.

A brain injury may vary in degree from a simple, mild concussion to a very severe contusion or laceration. In addition it may be associated with an intracranial hemorrhage. In concussion there is unconsciousness for a variable period of time, depending upon the severity of the injury. The unconsciousness is usually of short duration and the patient recovers rapidly with no disabling symptoms or impairment.

In contusion and laceration unconsciousness is more prolonged and there is structural damage to the brain. These injuries are frequently complicated by some degree of intracranial hemorrhage, most frequently subarachnoid or minute intracerebral hemorrhages and sometimes by subdural or extradural hemorrhage. There is apt to be associated an edema of the brain in a variable degree. The edema plus the accumulation of blood and fluid in the cerebrospinal spaces are the causes of an increased intracranial pressure.

Before taking up the actual treatment of the brain injury we should consider the patient's condition immediately after the accident. It is best not to move him any more than absolutely necessary. He may not only be in shock but there may be a ruptured blood vessel inside the skull and the best way to stop it is to keep the patient at absolute rest. External bleeding should be controlled as far as possible by pressure bandage or sutures. Should the blood pressure be abnormally low and a condition of surgical shock exist, the administration of fluids or even a blood transfusion may be indicated. If the patient is in collapse and unconscious, due to injury of the central nervous system, with a normal blood pressure, it is best to keep him quiet and do not administer fluids. It the patient is quiet and unconscious he should not have morphine administered even though he has

to be transferred to a hospital. The morphine acts as a further depressant to the vital centers in the brain, masking symptoms and interfering with the size and reactions of the pupils. The patient should not be rushed to the x-ray room unless an emergency exists, such as extradural hemorrhage, when we wish to obtain information of a fracture crossing the groove of the middle meningeal artery. It is advisable to have x-ray examination before operating for a compound depressed fracture, but then it can wait until after recovery from shock.

The principal treatment of a brain injury after recovery from the initial shock consists of relieving the increased intracranial pressure. This will vary somewhat depending upon the cause of the pressure.

Intracranial hemorrhage in the nature of a localized hematoma will require an operation for its removal and anything short of this will be of little avail. The typical example of a localized clot is an extradural hemorrhage. This condition frequently follows light blows on the head and in the temporal region. The blow is of sufficient degree to cause a fracture of the skull in the temporal region where the middle meningeal artery is ruptured by the sharp edge of bone. There may be a history of a lucid interval manifested by temporary unconsciousness followed by a period of consciousness during which there are progressive signs of increased intracranial pressure until the patient again becomes unconscious. The signs of increased pressure are severe headache, nausea and vomiting, slowness of the pulse rate, increasing stupor, and elevation of the systolic blood pressure with lowering of the diastolic, giving a high pulse pressure. Sometimes there is a paralysis or a convulsion on the opposite side of the body and with the hemorrhage on the left side there may be aphasia. During the stage of medullary compensation the systolic blood pressure is elevated and the pulse rate is slow, but during decompensation the pulse rate increases and the blood pressure falls progressively until death intervenes. One of the most important signs of extradural hemorrhage or other local compression of the brain is a dilated and fixed pupil on the same side as the hemorrhage. In order to recognize the early signs of compression it is routine to have the nurse or intern record the pulse, respiratory rate and the blood pressure every half hour for the first few hours or day after the patient is admitted. Likewise the patient's pupils should be observed at frequent intervals and the patient aroused if asleep to make sure he is not unconscious. It is necessary to make an opening in the temporal region to remove the clot and control the bleeding vessels. Spinal puncture does no good and may do harm by reducing the intracranial pressure, allowing an increase of the hemorrhage and further compression.

Subdural hemorrhage may be acute or chronic. The hemorrhage is localized on the surface of the brain on one side, but in one-third of the cases it is bilateral. If the clot has existed for several weeks a membrane is formed about it which converts it into a cyst.

This cyst gains in size so that there will be symptoms of progressive increase in intracranial pressure as seen in brain tumor. In the acute stage the symptoms of compression come over a shorter period of time, before nature has had time to lay down a new membrane. In either case there is the history of a lucid interval somewhat like that of extradural hemorrhage except the free interval is more prolonged over a longer period of time. Subdural hematoma follows minor head injuries as in extradural hemorrhage. The treatment is removal of the clot by operation.

When a brain injury is associated with subarachnoid hemorrhage there are signs of meningeal irritation like a meningitis. The patient will have stiffness of the neck, irritability, fever, leukocytosis, headache and vomiting. In this condition lumbar puncture is definitely indicated and necessary to relieve the patient. This constitutes the principal indication for lumbar puncture in acute brain injury. Here the puncture is diagnostic as well as therapeutic. It tells us that there has occurred some intracranial hemorrhage and we can determine the degree of pressure by recording the pressure with a manometer and relieve the symptoms by withdrawal of the bloody fluid. In extradural hemorrhage the spinal fluid is clear but under increased pressure. In subdural hemorrhage it will be clear unless some of the blood seeps into the subarachnoid space, in which case it will be blood tinged. Localized hemorrhage in the

subdural or extradural space can not be relieved by lumbar puncture.

Likewise intracerebral hemorrhage either large or small can not be drained by spinal puncture. Should the hemorrhage be large and sufficient to produce focal symptoms or signs of compression an exploratory operation may be done to remove or drain the hemorrhage.

We have considered the treatment of intracranial hemorrhage, one of the causes of increased intracranial pressure, but now we must take up edema of the brain, the other major cause of pressure. Cerebral edema is a natural result and reaction of the brain to trauma. It may be impossible to prevent edema from occurring and to prevent it may be harmful in some cases. However, it may be kept down to a minimum by judicious use of fluid limitation and by increasing fluid elimination. A moderate amount of edema will do little or no harm if it does not interfere with the circulation and the functions of the brain centers or nerve pathways. Should cerebral compression be threatened by the edema, adequate measures should be instituted to offset it. The fluid intake may be limited to 1000 to 1500 cc. daily and the fluid eliminated from the body by the use of saline laxatives, preferably magnesium sulphate. Hypertonic glucose, 50 cc. of 50% solution given in the vein several times daily, is sometimes used which definitely and temporarily relieves increased intracranial pressure. It has the advantage of giving nourishment as well as dehydration to the patient. Elevation of the patient's head tends to relieve intracranial pressure by lessening the hydrostatic pressure and encouraging the venous return from the head. An ice cap to the head is frequently used, chiefly to make the patient more comfortable and for relief of headache.

Subtemporal decompression is not often done today for the relief of intracranial pressure due to edema of the brain. It is more often done for the relief of pressure due to localized hemorrhage associated with the edema. It is also indicated when the patient is in a stage of severe compression and the other methods of relief of pressure are inadequate and producing no results. It is not easy to tell from the clinical examination whether we are dealing with compression due to edema or a localized blood clot. In this case it is advisable to make small drill hole openings under local anesthesia on one or both sides in the temporal or parietal regions to rule out a localized clot. There is little or no harm done to the patient by these small drill hole exploratory openings which are equivalent to the openings made for a ventriculography.

One of the frequent complications of fracture of the skull is meningitis resulting from a communication between the cerebral subarachnoid spaces and the middle ear or nasal accessory sinuses. This will be associated with a cerebrospinal fluid leak from the ear or the nose respectively. It is advisable not to pack the ear to stop the leak but to cleanse the external ear with alcohol or some other antiseptic and apply a sterile dressing to absorb the drainage. With the leakage from the nose the patient should be encouraged not to sneeze or blow his nose which would reverse the circulation and hasten the onset of meningitis. It is sometimes advisable to explore intracranially for the opening in the dura and repair the rent with a piece of facia or muscle to prevent a usually certain fatal meningitis.

A point that is not frequently stressed is the care of the unconscious patient and the feeding problem he presents. Every unconscious patient should be put on his side or face so that saliva and secretions can run from his mouth. In some hospitals a patient is allowed to remain on his back, to make gurgling sounds with each respiration as he aspirates and expels the secretions between the pharynx and the trachea. This will most likely lead to aspiration pneumonia. This fluid may be removed by postural drainage and I have seen patients' lives saved by elevation of the foot of the bed. In the unconscious patient there may be swallowing difficulty with coughing in which case nothing should be forced by mouth. It is safer and easier to give the patient feeding by a nasal tube which may be inserted and left in place for several days at a time.

In conclusion I wish to emphasize the proper treatment of lacerations of the scalp especially when they overlie a fracture of the skull, and in every case the underlying skull should be examined before closing the scalp wound. The early recognition of a localized

intracranial hematoma is urgent and the patient operated on if his life is to be saved. It is advisable that every patient with a skull or brain injury be admitted to a hospital for observation soon after the accident to prevent delay in the treatment of any emergency which may arise. One should delay in doing a lumbar puncture until there are signs of a diffuse hemorrhage in the subarachnoid space. Every effort should be made to control the intracranial pressure due to edema by dehydration rather than by operation although exploratory operations are sometimes necessary to rule out an intracranial hemorrhage. The proper management of complications and adequate nursing care are important factors contributing to the patient's recovery.

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ENDOCRINOLOGY IN THE PSYCHONEUROSES*

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The psychoneuroses are defined as a state of involuntary retreat from an unrecognized intolerable situation superimposed upon an inherent unstable emotional mechanism in which the victim lives in a world of reality. This mental residence contrasts the psychoneuroses from qualitative psychoses. In the latter, he dwells in a realm of fantasy. The psychoneuroses include hysteria, neurasthenia and psychasthenia. Generally speaking, hysteria simulates brain and spinal cord diseases; neurasthenia imitates physical disabilities, and psychasthenia suggests mental misalignment—not insanity.

To elicit the intolerable situation has heretofore been considered psychoanalysis. This term, in good company, is a pure entity. It has become a bastard in the hands of quacks, who with all the working arrangement of the clairvoyant, minus the purple curtain, have besmirched a good medical expression. Freud seems to have carried it too far into the sex paraphilias.

Before entering into the stated topic for discussion, a little story suggested by an article of Doctor Hall of Richmond, and often repeated to my patients, may help family physicians elicit an intolerable situation. It often brings the situation to light or enough fragments of it that it may be pieced together.

Let us picture a bungalow with an attic and a cellar. The family lives on the first floor in an orderly manner. Any member of that family can locate familiar objects in the dark. This floor represents the conscious mind in every day use.

Winter clothes are hung in the attic during the summer months and summer clothes placed there during the winter period. The owner knows and can well describe each garment. However, should he attempt to located one, he might have to look into several bags before the desired suit could be brought out. This attic depicts memory or mental inventory stored for definite future use. One may have to search his memory for the right word or phrase, but it is there and he knows that it is there and it can eventually be produced.

But in the cellar, there has accumulated odds and ends, classified by the wife as junk but cherished by the owner as of potential usefulness. When he needs something, he must search the cellar and when he fails to find the article, he is not sure that he did not overlook it. The cellar represents the unconscious mind. It is so far quite harmless.

Now let us say that this is a topsy-turvy cellar. Among the forgotten items on the bench is an oiled rag. Because of spontaneous combustion, it begins to smoulder. If found because of the smoke and immediately discarded, no lasting harm or inconvenience would result for the house could be aired to free it of smoke. Besides, the incident would probably cause the owner to clean up and take inventory, relegating much to the dump heap, If the rag is not observed in time, it might ignite and fire destroy the entire structure. Then I ask, "What does the oiled rag represent in your case."

But cellars may be kept orderly. It usually follows that cellars of children of orderly parents are kept well. Likewise, something akin may be handed from parent to offspring to determine how this mental cellar shall be kept. We know that family characteristics of expression, statute and complexion persist. This has been accepted as an endocrine factor. It is but reasonable to assume that the endocrine balance or imbalance may determine the stability or instability of the emotional mechanism.

*Read before the Annual Meeting of the Florida Midland Medical Society, Plant City, Oct. 27, 1936.

In 350 fairly well worked out cases prepared for a staff meeting last year, there has not appeared a normal endocrine balance in patients presenting symptoms of psychoneurosis. Whether this is a cause or a result, I do not know. Further, over 90% were rehabilitated when the endocrines were balanced artificially. Many cases had had much psychotherapy including psychoanalysis along with occupational therapy by outstanding colleagues. When endocrine therapy was established without further changing treatment, definite behavior changes towards normal were noted. Artificial replacement has been generally supplanted by a physiologic recovery with continued unaided health. In cases, not previously treated by the orthodox methods, psychotherapy, recreational therapy and often physiotherapy were also prescribed. One should use the good from all types of therapy and not become narrow in any one phase.

It is unfair to stamp one a psychoneurotic until much care has been exercised to prove he or she is without organic trouble. Several years ago, a woman was referred to me with the diagnosis of neurasthenia by a large northern clinic. Her complaint was an excruciating pain in the lower right chest and many of the usual syndromes of the neurotic. Her intolerable situation seems to be family and financial difficulties. I did not further examine her but tried to talk her out of her pain. She was stubborn and went back to Pennsylvania to die of cancer of the lung several months later. Therefore, I don't care where they come from, but my minimum routine covers the following items: general physical and neurological examination; urinalysis, blood cell count and blood Kahn test; metabolic reading; glucose tolerance test; general and gastro-intestinal fluoroscopy with barium. Even then I often miss something as apparent as a nose on a face.

Doctor Wolf, in his recent book, states that the pituitary gland is the key gland to the endocrine system and that the suprarenal gland is the trigger for quick response. He outlines the function of the anterior lobe as: growth, gonadtrophic, thyrotrophic, adenotrophic, lactogenic, raises blood sugar, stimulates insulin production, controls nitrogen metabolism, controls fat metabolism and parathyrotrophic.

The parathyroid metabolism, controlled by the last mentioned anterior pituitary hormone, seems to play the most important part in the emotional mechanism of the patient. Yet you probably noticed that calcium and phosphorus determinations were omitted from the routine examination. In the 350 cases mentioned, the calcium followed the metabolic and sugar readings. The calcium determination was discontinued from routine analysis because of the time consumed and technical difficulties encountered by the test.

A low metabolic reading with supporting low sugar curve apparently due to compensatory hyperinsulinism were accompanied by a high serum calcium content. The reverse held true. Occasionally the metabolism and glucose tolerance curves do not agree, probably due to insulin exhaustion and noted in cases of over three years standing. Then a serum calcium analysis is done.

Depressed patients show increased calcium content and excited ones show decreased calcium percentage as a rule. It is possible that if soluble calcium determinations had been run, the findings would have been constant. However, clinically, hematoporphyrin has given good results in about 50 cases of the depressed type. These include both the psychoneuroses and typical involutional melancholia. In the latter, it is about 60% effective. This is contrary to a few critics of the drug. In about a dozen early cases after hematoporphyrin was introduced, weekly serum calcium tests were run and the calcium content did drop with its use. The normal calcium amount is from 9 to 11 mg. per 100 mil. of blood. When the serum calcium reached 11 or slightly lower, the depression in all this small group vanished. In the involutional melancholia failures, hematoporphyrin did not lower the calcium content.

Calcium, parathyroid hormone and vitamin D do quiet people. As this paper is prepared, eleven cases of agitation of which two were in mania of cyclothymia have recovered. The twelfth case was a girl of 17 diagnosed hebephrenic schizophrenia with marked agitation. She improved until her mother considered her normal in one week. The mother refused sufficient hospitalization and returned to a distant city. Further results are unknown.

In giving hematoporphyrin, symptoms must

be watched for the patient will go from depression to excitement. This has happened in a few cases, but all returned to normal uneventfully. The point of injection must be protected from sunlight, for in one case, the nurse gave it into the patient's arm because the patient was too confused to cooperate. An ulcer difficult to heal about 4 inches long with a disagreeable keloid on healing resulted.

When endocrine analysis and synthesis have become perfected by which the individual hormones of the anterior pituitary gland may be marketed, it will be much easier to correct dysfunction at the fountain head of the system. As it is, whole gland extract, with occasional exception and they of little use in psychiatry, must be used. Anterior pituitary is therefore limited in its use, as for example it contains a substance to raise blood sugar and another to stimulate insulin production. Pending this time of purification, we must continue to add other gland products.

The most common and useful of these is the ovary. We know that the female cycle is begun by a pituitary hormone, Prolan A, and continued by another, Prolan B. It has been proved that the estrogenic hormone constantly increases in concentration until progestin, developed during the last two weeks of the cycle, fails. Then the estrogenic hormone causes destruction of the endometrium without restraint from the pregnancy hormone. We have seen women become extremely nervous and irritable at menstruation and the same women appear emotionally stable throughout gestation. Reversely, we have observed apparently normal women break emotionally during pregnancy. The knowledge of gland physiology and its application will correct many cases that are puzzling to obstetricians. There is too much tendency to give an estrogenic hormone in all cases, and in pregnancy it is certainly contraindicated.

In the general run of psychoneurotic cases, I find corpora lutea of advantage when well timed. It seems superior to its stated active principle recently marketed. Since the latter should be more effective if it were the only content of the parent substance, it must be that an unidentified hormone is carried by the former that is excluded in the process of refinement. Gynecologists do not find it of value in their work. By fortifying oral administration of whole ovary by an occasional dose of corpora lutea with theelin substituted when progestin should normally fail, many emotionally unstable cases are kept on an even keel.

In my early practice the diagnosis of goitre was a throat tumor, rapid pulse and exophthalmos. By doing routine metabolic readings and glucose tolerance tests, I find many unsuspected cases of both hyperfunction and hypofunction. Many of the tumor masses with rapid pulse represent compensatory enlargement for a defective thyroid.

Thyroid substance is specific for the underfunctioning gland. In nearly ten years, I have not had a case go to the surgeon in the hyperthyroid state. Competent x-ray therapy has given symptomatic relief and normal readings without fail.

When the thyroid, parathyroids, gonads and suprarenals become asthenic, the blood sugar raising hormone of the pituitary seems to call upon the isles of the pancreas to compensate and the sugar curve is low. This seems to persist for three years or longer before insulin shows failure. The early case will attend to itself with other glandular help or it may show definite hyperinsulinism. The late cases need artificial insulin introduced to help the islands to come back to normal function. Most cases eventually function without insulin.

It is naturally rare if not impossible to have one gland involved alone. Mental symptoms are usually associated with hypofunction. This makes therapy much simpler, because it is easier to add than to detract.

IN CONCLUSION:

1. I believe that functional psychiatry alone is antiquated. It has developed excellent points which should be used. Nothing good should be discarded nor should one become narrow on any one phase of medicine.
2. No nervous patient should be dismissed until comprehensive examination has been made including the endocrine system.
3. The nervous patient is sick. If the medical practitioner does not attend to his wants intelligently, quacks will continue to flourish because they will do something tangible and apparent. Inattention is just as cruel and, in suicidal people, just as fatal, as ignoring an acute appendicitis.

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AMEBIASIS*

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Chattahoochee

During the latter part of 1934 and early part of 1935 there was a definite increase in the number of cases of amebic dysentery at the Florida State Hospital and since that time over two hundred cases have developed in this institution. This was quite disturbing to the staff of the hospital, and many investigations were made to determine the cause of the increase. The food and water supply was checked thoroughly and it was finally decided that since the cases were developing in certain wards, usually among untidy patients, and since none of the nurses or doctors had become infected, it was a hand-to-mouth infection. After isolation of all cases there was a definite decrease in cases, but isolation did not entirely remedy the situation. Cases continued and will continue to develop occasionally, inasmuch as there is a large number of new patients being admitted each month, some of whom may be carriers, with no symptoms of the disease.

Before present day drugs came into use, amebic dysentery carried a very high mortality rate. With present-day methods of treatment the prognosis is excellent except for the patient who is improperly treated, or in whom the condition is not recognized. Here I would like to stress the importance of a stool examination of patients with gastro-intestinal complaints, as from 5 to 10 per cent of the population of the United States is infected with Endameba histolytica. This condition is no longer considered entirely a tropical or subtropical disease but is found in the colder climates as well. The symptoms vary from mild to severe and often there are no symptoms present in the carrier, which means the physician must be more on the lookout.

By the term amebiasis is meant the invasion of the tissue of man by the pathogenic ameba, Endameba histolytica. This invasion usually takes place through the mucous membrane of the large intestine and the lesions are most commonly found in the rectum and just below the ileocecal valve, though in severe cases the entire intestine may be invaded. In some patients the lesions heal so quickly that no symptoms are present, while others suffer from a bloody mucoid diarrhea.

The life cycle of the Endameba histolytica consists of the vegetative, a precystic and cystic stage, and when the cysts are swallowed they usually pass unchanged until they reach the large intestine. Here the wall of the cyst becomes permeable and four nucleated ameba emerge and after other changes the four divide into eight, which become motile and are known as trophozoites, which attack the mucous membrane of the intestine producing ulceration. The trophozoites multiply in the tissue and lumen of the intestine but lose the ameboid activity before the precystic stage begins; the precystic forms do not invade the tissue but form cysts which are passed in the feces and again may infect man.

Food and drink are the usual sources of transmission of the Endameba histolytica. These may became contaminated by carriers who are food handlers, by the soil around springs and wells which may be polluted with feces, from vegetables grown with human excreta used as fertilizer, or from fly droppings. Flies may transmit the disease by carrying fecal matter on their feet if they quickly light on moist food stuff after leaving the contaminated material. This latter source of transmission is, of course, more of a hazard than usual in a hospital for mental cases where a large percentage of patients are untidy and eat trash, dirt, or anything they find.

The cysts of Endameba histolytica are readily killed by drying, and there is very little danger of contamination through dust, which was long thought to be one method of transmission. The thermal death point by the eosin test is given at 68° C. and the cysts withstand this temperature for five minutes. So far, chemicals have proved worthless in destroying the cysts.

The virulence of the Endameba histolytica is still a matter of discussion, but it is accepted that the amount of resistance of the individual plays the major part as in individuals who are infected with the Endameba histolytica, and whose resistance becomes lowered by some other cause often develop severe symptoms and die of the amebic infection. Age, sex and race have very little influence on the disease but from statistics is it shown

*Read before the Leon - Gadsden - Liberty - Wakulla - Jefferson County Medical Society, Chattahoochee, April 15, 1937.

that amebic infections occur most often between the ages of 20 and 45 but no age is exempt. It is found less frequently in females than males and affect all races alike, though the white race living in the tropics suffers more severely than do the natives. The climate seems to play a large part, as the hot, moist climate is more favorable to the disease and it is more noticeable in the warm climate during the rainy season, naturally increasing the chances of contamination. So far nothing has been proved regarding natural immunity.

Amebic dysentery may or may not occur in epidemic form, but we are all familiar with the epidemic originating in Chicago in 1933, infecting a large number of people visiting the World's Fair, who carried the infection back to other cities. This was traced to two hotels and was largely a water-borne epidemic which resulted in some 800 cases.

Since the symptoms of amebic dysentery vary from very mild to severe, it is felt the word "dysentery" is misleading, as when different symptoms are present the case is usually well advanced, with lesions throughout the intestinal tract. Doctor Craig in his book on "Amebiasis and Amebic Dysentery" divided the individuals infected with Endameba histolytica into four classes. Class 1 includes those who harbor the parasite without symptoms of the infection, or the so-called healthy carrier. Class 2 includes those who present indefinite and slight symptoms connected with the gastro-intestinal and nervous systems, and who are also usually considered as healthy carriers. Class 3 includes those who suffer from recurring attacks of diarrhea accompanied by other symptoms. Class 4 includes those suffering from acute or chronic amebic dysentery.

The symptoms of the disease vary, but among the common complaints, abdominal distention is most frequently heard. The patient usually complains after taking food. The distention is accompanied by gaseous eructations and the passing of large amounts of gas per rectum. The distention often is very painful and colic-like. In carriers of Endameba histolytica constipation is a frequent symptom, which may occur at intervals or be constant. Diarrhea may also occur in the carrier state. However, some carriers present no symptoms or give any history of constipation or diarrhea. Recently a number of kitchen employees were required to have physical examinations, including stool examinations. These employees gave no history of any gastro-intestinal disturbance, but a fairly large percentage were positive for cysts. Among the other common symptoms are loss of weight, disturbance of appetite, nervousness, muscle pains, and occasionally, slight afternoon rise in temperature. Frequent localized areas of tenderness of the abdomen are found, which may be mistaken for subacute or acute appendicitis, or, in the gastric region, cholecystitis. It is believed by some physicians that there is a form of cholecystitis caused by the invasion of the gall bladder by the Endameba histolytica.

The incubation period may vary from a few days to a year. In acute amebic dysentery the onset is usually rather sudden. The patient develops an acute dysentery, having from 6 to 10 stools in 24 hours which contain blood, mucus and pus. In two cases seen there were rather large sloughs of mucous membrane present in the stool. There is a slight rise of temperature; the patient complains of chilly sensations and usually, very severe cramp-like pain in the lower abdomen, more severe just before the bowels move. Nausea and vomiting may be present at the onset. The patient in a few days becomes anemic in appearance, and in a few cases a slight jaundice is noticed.

Much has been written concerning the complications of amebic dysentery. Among the complications usually listed are abscess of the liver, abscess of the brain, abscess of the lung, abscess of the spleen, invasion of the skin, appendicitis, peritonitis, and intestinal hemorrhage. The most common of these is liver abscess, which some men state occurs in as high as 5 per cent of all cases of ameba dysentery.

Up until the present time there have been no complications developing in any of our institutional cases. Why no liver abscesses have developed I cannot explain but when it is considered that from 5 to 10 per cent of the population is infected with Endameba histolytica, with only a small number of cases of liver abscess, then the percentage must be low. I do feel that all patients treated should be followed closely for months to be sure they are free of the infection.

At this point I may say a few words concerning the handling of cases in this institution. When patients in the general wards develop any symptoms of the disease they are sent into the general infirmary where warm stool examinations are made, as well as cold specimens stained for cysts. If found positive, the patients are isolated and treated until the symptoms disappear and the stools are negative. They are transferred to the general wards but kept under isolation, and receive courses of treatment at intervals of six weeks until they have received two to three courses of treatment, regardless of the stool examination. If at this time they are considered cured, their stools are examined for four days; if negative, they are transferred back to the wards, but are called in for stool examinations at intervals of two months. So far in the white male department, the stools of only two patients taken out of isolation have been found to contain cysts. These patients, of course, were put back in isolation and again treated.

I have charted the last 44 cases treated. All of these were white men, most of whom were very untidy and deteriorated. Twenty-two of these patients were treated with emetine hydrochloride, 1 grain daily, for ten days, followed by carbarsone capsules 1 (containing 3¾ gr.) three times a day for ten days. These patients were given quinine enemas daily. In most of these cases it required from 3 to 4 courses to get a negative stool, and in three cases, after receiving two courses of the above treatment, a change was made to chiniofon with negative results after the first course of treatment. The other 22 cases were treated with chiniofon tablets 3 (grs. 4) three times a day for ten days. In all these cases stool examinations were negative after the first course with the exception of four cases, and two of the four were positive after the second course.

Chiniofon is a non-toxic drug when given in therapeutic doses by mouth or rectum. In some cases chiniofon may produce a diarrhea and it is necessary to cut down the dosage. Emetine has a cumulative action and may produce toxic symptoms, having a powerful action on the heart muscles and should not be given in cardiovascular cases.

The control of this disease is largely a public health problem. The public must be educated, personal hygiene stressed, the food and drink must be protected, and provision made for the proper disposal of feces, and the detection and treatment of carriers.

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PRE-CONVENTION MEETING

The pre-convention meeting of the Florida Medical Association will be held Sunday, January 16, 1938 at the Hillsborough Hotel in Tampa. The Association's Committee on Scientific Work will meet at 10 a. m. All members of this Committee are urged to be present promptly at 10 a. m. An unusually large number of applications have been received for places on the scientific program of the Sixty-fifth Annual Meeting to be held in May, at Miami. Dr. Leigh F. Robinson, Chairman, is anxious to have every member of his Committee present, in order to have their counsel and advice in making plans for the scientific program.

The Executive Committee of the Association will meet at 11 a. m. A number of items of new business are to be taken up for action. One item of particular importance is provided in Chapter 7, Section 2 of the by-laws. This is a new requirement, included in an amendment acted upon at the last annual meeting of the House of Delegates: "Invitations for the next annual meeting of the Florida Medical Association shall be presented to the Executive Committee (or Board of Governors) prior to or at the pre-convention meeting. This Committee shall investigate the facilities for entertaining the Association and the feasibility of holding the annual meeting in such places, and recommend the place most desirable, at that time, to the House of Delegates at its first regular meeting, for approval. In the event there is no invitation, the Executive Committee shall recommend the place most desirable." This action of the House of Delgates was intended as a constructive move to assure adequate facilities for holding a successful annual meeting. Dr. Gilbert S. Osincup, Chairman of the Executive Committee, requests that every member of the Committee plan to attend the meeting at 11 a. m., Sunday, January 16, at the Hillsborough Hotel, Tampa.

The annual meeting of the Council will be held following the luncheon scheduled for 12:30 p. m., Sunday, January 16, 1938, at the Hillsborough Hotel, Tampa. At that time the councilors' reports will be read and turned in for publication in the Association's Journal. Each councilor is requested to be present and read his annual report. Councilors who find it impossible to attend the annual meeting of the Council are requested to forward their reports to Dr. W. McL. Shaw, Chairman of the Council, P. O. Box 1018, Jacksonville. Councilors are requested to refer to Chapter 6 of the By-laws for instructions concerning the preparation of their annual reports. The Council, through its Chairman, will make an annual report to the first session of the House of Delegates at the annual meeting in May, 1938, at Miami. In addition to the annual reports of councilors at the pre-convention meeting to be held in Tampa, January 16, some important items of business will come up for action. The dates will be set for the annual meetings in the six medical districts. In order that there may be no conflict in the dates of these annual district medical meetings, each councilor is requested to investigate local conditions and be prepared to select the date most suitable to the doctors in his district.

Chapter 7, Section 21 requires each committee to have a report of its activities to submit to the annual pre-convention meeting and to make its final report to the House of Delegates at its first annual session. All reports of committees named in this chapter must be approved by the House of Delegates. Chairmen of all regular committees are requested

to notify the members of their committees in case they deem it advisable to have a meeting Sunday forenoon, January 16, in Tampa. The question of calling all committees together for separate meetings at the pre-convention meeting is left entirely to the discretion of the chairmen, with the exception of the Committee on Scientific Work and the Executive Committee, as the chairmen of these two committees have already scheduled meetings.

The Constitution and By-Laws were brought up-to-date and published in the November, 1937, Journal of the Florida Medical Association. Reprints of the Constitution and By-Laws in pocket size will be mailed to officers, secretaries of component societies, or individual members upon request.

COMBAT TUBERCULOSIS

Another year, another Christmas Seal but the same cause—tuberculosis. The Christmas Seal Sale, sponsored in Florida by the Florida Tuberculosis and Health Association and its affiliated groups, has supported physicians of the state in their efforts to make Florida a better and more healthful place in which to live. Cooperation with the private physician has been of paramount importance and as a result many early cases have been brought to his attention, x-ray examinations have supplemented his findings and kept him informed of progress and prognosis. Outstanding authorities have been brought to Florida for meetings and material has been supplied on scientific findings and new methods.

Christmas Seals kept the sentiment aflame for a State Tuberculosis Sanatorium and today it is a reality—to be opened for patients about January 1, 1938.

Christmas Seals have helped train two classes of Negro physicians in the diagnosis and treatment of tuberculosis so they may discover and treat the disease which so ravages the colored race, menacing both white and colored, young and old.

The Committee on Tuberculosis and Public Health of the Florida Medical Association has watched carefully over the program supported by the Christmas Seals. With the opening of the 1937 sale, Thanksgiving Day, it recommended Christmas Seals for your purchase and use.

PRINCIPLES AND PROPOSALS OF THE COMMITTEE OF PHYSICIANS

On November 19 and 20, secretaries of state medical societies and editors of state medical journals assembled at the American Medical Association's headquarters for their annual conference. At this meeting an editorial was read and, at the request of those present, was distributed in galley proof form with the understanding it would not be released until the following Sunday. The editorial appeared later in the American Medical Association's Journal. Since forty per cent of our readers do not receive the A. M. A. Journal, it is reproduced here.

The Board of Trustees (A. M. A.) has especially authorized the publication of the following statement:

Following the publication of the report of the American Foundation Studies in Government, a small group of physicians, assembled in New York, developed certain principles and proposals which have since been circulated by a self-appointed Committee of Physicians among the medical profession of the United States, with a view to obtaining signatures in their support. During a period of approximately six months, some 430 medical men have apparently permitted the use of their names. Early in November the self-appointed group of physicians released to the press for Sunday, November 7, a statement of principles and proposals to which the names of the 430 signers were affixed. The newspapers generally heralded this action as a revolt against the American Medical Association, in a great majority of cases indicating that there was a revolt in behalf of "state medicine." The publication of this manifesto and the attached signatures has been heralded with glee by many of those who have been opposing the American Medical Association in behalf of cooperative practice, sickness insurance, and various fundamental changes in the nature of the practice of medicine. Within the last week another series of proposals has come from another self-appointed group requesting signatures of physicians. This series of proposals includes the suggestion for enabling legislation for sickness insurance.

The American Medical Association is an organization of physicians along strictly dem-

ocratic lines. Representatives of county medical societies send delegates to state medical societies and these, in turn, send their delegates to the House of Delegates of the American Medical Association. It is possible for any physician, through his delegate, to obtain consideration of any proposal which he may wish to bring to the attention of the House of Delegates. At the Atlantic City session the delegates from New York State presented these principles and proposals, slightly modified, as an action of the House of Delegates of the New York State Medical Society. They were carried before a reference committee and, in several sessions of that reference committee, considerable numbers of physicians presented arguments for and against their adoption. The House of Delegates, however, after thorough consideration of the report of the reference committee, and with full cognizance of the method of development of these principles and proposals, and of the considerations which were involved in their passage by the House of Delegates of the New York State Medical Society, did not accept them. The House of Delegates did, however, point out the willingness of the medical profession to do its utmost today, as in the past, to provide adequate medical service for all those unable to pay either in whole or in part.

Why, then, any necessity for the circulation of petitions presenting proposals for fundamental changes in the nature of development, distribution and payment for medical service? Is there a well designed plan to impress the executive and legislative branches of our government with the view that the American medical profession is disorganized, distrustful of its leaders, undemocratic in its action and opposed to the best interests of the people? Who may profit from such evidence of disorganization? Is there any evidence that the self-appointed Committee of Physicians and the 430 physicians who have affixed their names to these principles and proposals are any better able to represent the opinion of the American medical profession than the democratically chosen House of Delegates of the American Medical Association — one of the most truly representative bodies existing in any type of organized activity in this country today?

The House of Delegates has given its mandate to the Board of Trustees, to the officers and to the employees of the Association. That mandate opposes the principles and proposals emanating from the Committee of Physicians, and equally the new proposals. If the House of Delegates sees fit to depart from the principles now established, it will be the duty of the Board of Trustees, the officers and the employees of the American Medical Association to promote such new principles as the House of Delegates may establish. Until, however, the regularly chosen representatives of the 106,000 physicians who constitute the membership of the American Medical Association (now the largest membership in history) determine, after due consideration, that some fundamental change or revolution in the nature of development, distribution and payment for medical service in the United States is necessary, physicians will do well to abide by the principles which the House of Delegates has established. They will at the same time deprecate any attempts inclined to lead the executive and legislative branches of our government, as well as the people of the United States, into the belief that the American medical profession is disorganized.

Members of the medical profession, locally and in the various states, are ready and willing to consider, with other agencies, ways and means of meeting the problems of providing medical service and diagnostic laboratory facilities for all requiring such services and not able to meet the full cost thereof. The American Medical Association has reaffirmed its willingness on receipt of direct request to cooperate with any governmental or other qualified agency and to make available the information, observations and results of investigation, together with any facilities of the Association. Thus far, no call has come from any governmental or other qualified agency, for the cooperation of the American Medical Association in studying the need of all or of any groups of the people for medical service, to determine to what extent any considerable proportion of our public are actually suffering from lack of medical care. The offer still stands as evidence of the willingness of the American Medical Association to aid in finding a solution to any or all of the problems in the field of medical care that now prevails.

SAN FRANCISCO HOTELS

1938 AMERICAN MEDICAL ASSOCIATION ANNUAL SESSION

The Board of Trustees of the American Medical Association has appointed Doctor Howard Morrow of San Francisco as General Chairman of the Local Committee on Arrangements. Among other appointments of local sub-committees, Doctor Morrow has appointed Doctor F. C. Warnshuis, Chairman of the Local Committee on Hotels.

Fellows are requested to send in their requests for hotel accommodations to Doctor F. C. Warnshuis, Suite 2004, 450 Sutter St., San Francisco, California, giving names of members in party, type of accommodations desired, time of arrival and departure.

Assignment of accommodations and their confirmation will be made for each reservation request. Do not write directly to any hotel as *all* reservations will be cleared through the Hotel Committee.

Banquet Rooms and Special Dinners reservations must be made through the Hotel Committee. The same rule applies to special boards and allied organizational groups.

San Francisco affords first-class hotels capable of providing accommodations for 15,000 Fellows and members of their families. However, early reservations are requested to avoid confusion and to insure individual choice. A pleasing surprise awaits every Fellow in the hotel accommodations of the Golden Gate City.

Those planning to visit San Diego, Los Angeles, Santa Barbara, Del Monte, Yosemite, or other California cities are urged to write in advance for hotel reservations in these cities. Following the American Medical Association Annual Session, the Rotary, Kiwanis, and Shriners hold their annual sessions in California. It is quite probable that many of the members of these organizations will visit points of interest before their conventions, thereby creating heavy demands on local hotels throughout the State.

FOR SALE: Standard X-ray machine, electro-coagulation unit, instruments, instrument cabinet, examination table, water-cooled quartz lamp, complete medical library. Mrs. R. Leffers, Lakeland, Fla.

STATE NEWS ITEMS

The annual oyster roast for the members of the Riverside Hospital Staff and invited guests was held on the evening of November 23 at Dr. T. Z. Cason's farm on the St. Johns River. About 50 guests, including a number of out-of-town physicians were present.

A preliminary scientific program was held in the staff room of the Riverside Hospital, at which a symposium of diseases of the colon was given by Dr. J. W. Merritt, Dr. W. McL. Shaw, and Dr. Lucien Y. Dryenforth.

* * *

Dr. Paul G. Shell has opened offices at Tampa to take up the practice of medicine. Doctor Shell was formerly Director of the Broward County Health Unit.

* * *

At the October meeting of the American College of Surgeons held in Chicago, Dr. Duncan T. McEwan and Dr. C. D. Hoffmann, both of Orlando, were elected to Fellowship.

* * *

Dr. O. E. Harrell of Jacksonville has returned from an Army school at Carlisle Barracks, Carlisle, Pa., where he spent the months of October and November.

* * *

Dr. J. W. McMurray was recently appointed Director of the Broward County Health Unit with headquarters at Ft. Lauderdale. He was formerly Director of the Gulf-Calhoun-Franklin Unit with headquarters at Apalachicola.

* * *

Dr. John B. Black of Jacksonville, who is a lieutenant colonel on the staff of E. D. Rivers, Governor of Georgia, was luncheon host to Governor Rivers and party who attended the Florida-Georgia football game Saturday, November 6.

* * *

Dr. and Mrs. A. R. Beyer of Tampa returned recently from abroad. Doctor Beyer spent several months doing postgraduate work in Vienna.

* * *

Dr. Gordon H. Ira of Jacksonville was principal speaker at a recent meeting of the local Lions Club. Doctor Ira's talk, which was illustrated by lantern slides dealt with "Heart Disease."

Dr. J. O. W. Rash of Miami has returned from a three-weeks' vacation spent in Europe.

* * *

Application blanks are now available for space in the Scientific Exhibit at the San Francisco session of the American Medical Association, June 13-17, 1938. The Committee on Scientific Exhibit requires that all applicants fill out the regular forms. Application blanks may be obtained from the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago.

* * *

Dr. Samuel D. W. Light of Miami has returned from a two months' vacation spent in North Carolina.

* * *

Dr. Michael P. DeBoe of Miami announces the removal of his offices to the Huntington Building.

* * *

The Bureau of Air Commerce has requested the Aero-Medical Association of the United States to appoint a special committee for the purpose of instituting a pilot fatigue study. Dr. Ralph Greene of Coral Gables, now Medical Director of Eastern Air Lines and Medical Consultant for Pan American Airways, has been appointed chairman of the committee.

* * *

Dr. Herbert L. Bryans of Pensacola was elected president of the Gulf Coast Clinical Society at its annual meeting, held at Biloxi, Mississippi, November 3.

* * *

Dr. Kenneth Phillips of Miami recently attended the meeting of the American Congress of Physical Therapy, at which he presented a paper on "A Comparison of Fever Production by Physical Methods from a Physiological Viewpoint."

* * *

Dr. and Mrs. E. J. Melville of St. Petersburg have returned from a five months' trip on the freighter "Thurland Castle." Most of the summer was spent in the Orient and Australia.

* * *

Dr. J. N. McLane of Pensacola spent the month of October in St. Louis attending clinics at Barnes Hospital. While in that city, he attended the meeting of the International Medical Assembly.

Dr. and Mrs. F. S. Whitman of West Palm Beach, spent the summer at Esecola Lodge, Linnville, N. C. On his return trip, Doctor Whitman visited several cities and attended clinics.

* * *

Dr. and Mrs. S. B. Forbes of Tampa returned recently from Europe. Doctor Forbes spent several months in postgraduate work at Vienna.

* * *

Construction of a new $228,946 Nurses' Home at the Florida State Hospital at Chattahoochee, is now under way and is expected to reach completion in the Spring. The new building, which will replace the structure destroyed by fire last winter, will be the finest nurses' home in the state, Superintendent J. H. Therrell stated.

A two-story structure, the home will have two wings 310 feet in length, and will house 300 graduate nurses, student nurses, and office workers. All bedrooms will be outside rooms with connecting baths. Classrooms, a library, reading rooms, also trunk storage, ironing and laundry rooms, will be included. There will be visitors' rooms with private entrances and a recreation court in the rear.

* * *

Dr. W. McL. Shaw, roentgenologist of Jacksonville, was a recent visitor at the Florida State Hospital in Chattahoochee, accompanying Dr. J. G. Lyerly, neurosurgeon of Jacksonville, on his monthly visit.

* * *

Dr. T. Z. Cason of Jacksonville was guest speaker at a meeting of the Woman's Club of Starke, November 10.

* * *

The next meeting of the Southern Section of the American Laryngological, Rhinological and Otological Society will be held Monday, January 24, 1938, at the Georgian Terrace Hotel, Atlanta, Georgia. The meeting will open promptly at 9 a. m. There will be nine scientific papers presented by distinguished essayists. At 12:30 p. m. there will be a luncheon open to all members and guests. The business meeting is scheduled for 1:30 p. m.

Dr. William C. Roberts of Panama City has recently completed the construction of the William Carmel Roberts Clinic, which is located at 119 Cove Boulevard. The official opening was held on August 15 at which time the clinic was dedicated to the owner's father, Dr. W. P. Roberts of Dothan, Ala. Doctor William C. Roberts extends an invitation to members of the Association to visit him when in Panama City.

* * *

Dr. Carl E. Dunaway of Miami has recently returned from an extended vacation spent in North Carolina.

* * *

The radio program of the American Medical Association, which consists of dramatized health messages, for the coming month is as follows:

Dec. 29—Dietary Fads: facts versus fallacies in relation to prevalent false notions about diet.

Jan. 5—Sneezes and Sniffles: cause, spread, prevention of colds, pneumonia and influenza; importance of early medical care.

Jan. 12 — Scarlet Fever, Measles and Whooping Cough: modern attitudes toward these diseases; their prevention by community cooperation.

Jan. 19—Smallpox and Diphtheria: unnecessary diseases; preventable by immunization of infants.

These programs are presented over the Red Network at 2 p. m.

* * *

Dr. R. D. Thompson, superintendent of the State Tuberculosis Sanatorium, Orlando, was guest speaker at a meeting of the Lake County Federation of Women's Clubs, Mount Dora, November 23, at 11:30 a. m. On the same day, he addressed the Senior High School of Mount Dora on "Tuberculosis." In the afternoon, he attended the medical meeting of the Riverside Hospital, Jacksonville.

* * *

Dr. William H. Kupper has resigned from the State Hospital Staff to establish private practice in Hollywood, Florida, December 7. Doctor Kupper has been in charge of malarial therapy at the Hospital, which work is sponsored by the Rockefeller Foundation in collaboration with the State Board of Health.

Dr. H. Hamilton Cooke, Miami, was recently elected vice-president in the Section of Neurosurgery of the Pan American Medical Association.

The "Queen of Bermuda" has been chartered for the seventh cruise-congress. This boat was used for the last cruise and proved to be most ideal. The itinerary is a follows:

Leave New York	Jan.	15
Arrive Havana	"	18
(4½ days and 5 nights in Havana)		
Leave Havana	"	23
Arrive Port Au Prince	"	24
Leave Port Au Prince	"	24
Arrive Trujillo City (Santo Domingo)	"	26
Leave Trujillo City (Santo Domingo)	"	26
Arrive San Juan (Puerto Rico)	"	27
Leave San Juan (Puerto Rico)	"	27
Arrive New York	"	31

The main part of the Congress will be held in Havana at the National Hotel. The official hotel in New York is the Savoy-Plaza. All members of the Florida Medical Association are cordially invited to make this cruise and attend the meetings. Applications for reservations should be addressed to the Pan American Medical Association, 745 Fifth Avenue, New York City.

* * *

Dr. and Mrs. J. Raymond Graves of Miami have returned from a vacation spent in Europe.

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At the annual meeting of the Southeastern Branch Society of the American Urological Association, held at Birmingham, November 5 and 6, the following officers were elected: president, Dr. George Livermore, Memphis; president-elect, Dr. Earl Floyd, Atlanta; secretary - treasurer, Dr. Raymond Thompson, Charlotte, N. C. Members of the Florida Medical Association who attended this meeting were:

M. M. Coplan, Miami; James L. Estes, Tampa; W. L. Fitzgerald, Miami; William P. Farber, St. Petersburg; E. S. Gilmer, Tampa; H. B. Haisfield, Pensacola; Louis M. Orr, II, Orlando; A. L. Rowe, Lake Worth; E. T. Sellers, Jacksonville; Gideon Timberlake, St. Petersburg; and B. F. Woolsey, Jacksonville.

Dr. Julius C. Davis of Quincy is the new president of the State Board of Medical Examiners, effective November 7, 1937. Dr. Harold D. Van Schaick of Jacksonville was elected vice-president of the Board at the meeting in Jacksonville, November 15.

* * *

The October, 1937, number of Medical Economics comments on the new Designation Act in Florida. The comment appears under the heading, "Florida Tags Healing Arts" and states that "Florida has found a way to discourage professional swamis, nature healers, and their like from flying false colors. A new law requires that all who claim to be doctors shall post a sign at their office entrance. A shingle carrying merely 'Dr. So-and-So' is no longer enough. It must state to what branch of the healing art a man belongs."

* * *

In developing cooperative County Health Units in Florida, along with the active support of medical societies, the aid of the civic clubs has been invaluable. None has been more active than Kiwanis. Through the leadership of Dr. A. B. McCreary, Director of County Health Work for the State Board of Health, the following resolution was adopted at the Florida District Convention of Kiwanis at St. Augustine:

"Whereas, Public Health work as represented by the Unit plan fostered by the State Board of Health is recognized by medical and public health authorities as being the best and most adequate form of health service, and

"Whereas, as most of the Kiwanis projects pertaining to health, such as the safety patrol, underprivileged child and crippled children's work would be covered fully by such a move, be it therefore

"Resolved, that the Florida District make the creation of a full-time health service through the Unit plan under the supervision of the State Board of Health one of the major projects of Kiwanis,

"And Further, that such a plan be recommended and sponsored before Kiwanis International as a National and International project."

Dr. W. G. Miles, Chattahoochee, of the State Hospital staff, presented a paper on "Psychiatric Nursing" at the meeting of the Florida State League of Nursing Education in Tampa on November 3.

GROVER CLEVELAND HARDIE

Dr. Grover C. Hardie, pioneer physician of Ft. Pierce, died at his home on October 25, 1937, of coronary thrombosis.

Born at Pineda, Florida, July 31, 1888, Doctor Hardie was the son of J. F. and Lilla Dale Bass Hardie. He studied medicine at what was then the Atlanta College of Medicine, now Emory University, Atlanta, graduating with the class of 1911. He began the practice of medicine at Hahira, Georgia, where, on August 4, 1911, he was married to Miss Stella Jones, whose death occurred about a year ago.

In 1913, Dr. and Mrs. Hardie moved to Crescent, Florida, and two years later to Fellsmere, coming to Fort Pierce from the latter place in 1917.

Dr. Hardie was a World War veteran, having served as a first lieutenant in the Army Medical Corps, stationed at Fort Oglethorpe. He was a former president of the local Rotary Club; secretary and treasurer of the St. Lucie-Okeechobee - Indian River - Martin County Medical Society; local surgeon for the Florida East Coast Railway; and port surgeon for the U. S. Public Health Service. He was a member of the Board of Elders of the First Presbyterian Church. Other fraternal connections included Fort Pierce Lodge 87, Free and Accepted Masons; San Lucie Commandery, Knights Templar; Atlantic Lodge 30, Independent Order of Odd Fellows; and Indian River Camp 153, Woodmen of the World.

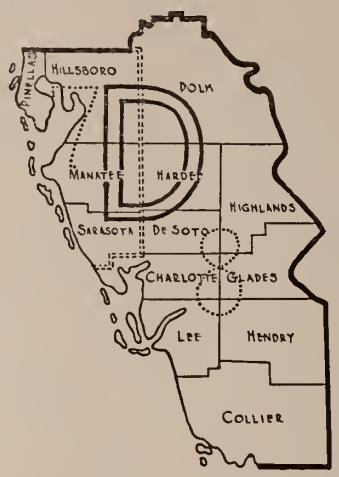
Doctor Hardie is survived by his son, Conrad, of Ft. Pierce, and a sister, Mrs. G. B. Horton, of Jacksonville.

Always of a cheerful, jovial disposition, Doctor Hardie carried sunshine into the homes and hearts of those whom he served, devoting his life to the alleviation of suffering and answering the call for help from whatever source or at whatever hour it came. His death came as a severe blow to his numerous friends.

Your membership dues of $10.00 are payable January 1. The secretary of your county medical society is a busy doctor. Why not give him your dues promptly?

ANNUAL MEETING SOUTHWEST MEDICAL DISTRICT

The first annual meeting of the Southwest Medical District (D) was held in Plant City, Thursday, November 11 at 3 p. m. The total registration was 57. Of this number 38 were doctors who are members of the county societies in this district; 3 were visiting doctors from Orange County; 2 from Duval County and 1 from Polk County. Seven were mem-



bers and guests of the Woman's Auxiliary. Firms having headquarters in this district, who exhibited at the Association's annual meeting, received an invitation to have their representatives attend this meeting.

In spite of a heavy rain and November 11 being a holiday, the meeting was well attended. All sections of the district were represented and the good fellowship throughout the entire occasion was evidence of a hearty endorsement of a district meeting.

The Local Committee on Arrangements, headed by Dr. Butler H. Sanchez, made elaborate preparations for the meeting. A projecting lantern was loaned by Dr. J. C. Dickinson and the assembly room in the city hall was nicely arranged for the convenience of the speakers and audience. A very unique arrangement was put into effect for darkening the room during the operation of the projecting lantern.

At 3 p. m. at the city hall, the scientific session was called to order by Dr. J. W. Alsobrook. Doctor Alsobrook read a wire from Dr. J. A. Simmons, Senior Councilor, expressing regret that it was impossible for him to attend, owing to illness. The address of welcome was given by Dr. George L. Cook. The first paper was read by Dr. Douglas D. Martin of Tampa, on "Appendicitis in Children." The next paper, on "Quinine Amblyopia," was by Dr. Shaler Richardson of Jacksonville. The last paper was titled "Disturbances of Thyroid Function" and read by Dr. Herman Watson of Lakeland. These papers were well received and the discussions were participated in so enthusiastically that the essayists realized the interest of those present in the subject matter presented. Those taking part in the discussions made a real contribution to the scientific session.

After a short recess, Dr. J. W. Alsobrook called the general session to order and called upon Dr. Edward Jelks, President of the State Association, for a short address. Dr. Shaler Richarson, Secretary-Treasurer and Editor of the Journal, was then called upon and these two officers presented to the group many interesting facts concerning the activities of the Association, as observed by your officers. Dr. Alsobrook then called on Dr. W. Henry Spiers, President-elect; Dr. H. Mason Smith, past president, 1926; Dr. O. O. Feaster, past president, 1936; and Dr. Gilbert S. Osincup, Chairman of the Executive Committee.

The question of the selection of a meeting place for 1938 was taken up and Dr. C. W. Larrabee of the Manatee County Medical Society extended a cordial invitation for the meeting to be held in Bradenton in 1938. The question was put to a vote and Bradenton was unanimously selected.

After the meeting refreshments were served at the Armory, followed by a banquet which appealed to the most critical taste. This banquet was served by the Woman's Auxiliary of the American Legion, Norman McLeod Post No. 26. The food was not only prepared to a queen's taste, but was daintily served by the ladies of the Auxiliary. A floor show followed the dinner. This part of the entertainment was composed entirely of local talent and the ap-

plause following each number demonstrated the appreciation of those present. Doctor Alsobrook, Junior Councilor, presided at the banquet and short addresses were given by Dr. George L. Cook, President of the Hillsborough County Medical Society; Dr. Edward Jelks, President of the Florida Medical Association; and Dr. W. Henry Spiers, President-elect.

REGISTRATION

Alsobrook, J. W., Junior Councilor.....Plant City
Thompson, Stewart, Managing Director...Jacksonville

MEMBERS

Austin, Edgar.....Plant City
Bidwell, A. M.....Tampa
Bird, D. Paul.....Lakeland
Black, R. C.....Plant City
Blake, W. C.....Tampa
Boling, John R.....Tampa
Boulware, J. R., Jr.....Lakeland
Clark, S. A.....Lakeland
Cline, R. L.....Lakeland
Cook, George L.....Tampa
Davis W. M.....St. Petersburg
Dickinson, J. C.....Tampa
Estes, James L.....Tampa
Farrington, Charles L.....Tampa
Feaster, O. O.....St. Petersburg
Harrison, M. M.....Bradenton
Holton, W. J.....Plant City
Knight, J. C.....Plant City
Larrabee, C. W.....Bradenton
Lowry, B. W.....Tampa
Lowry, James B.....Nichols
McConnell, W. C.....St. Petersburg
Maguire, T. C.....Plant City
Martin, Douglas D.....Tampa
Mills, Alvin L.....St. Petersburg
Murphey, David R., Jr.....Tampa
Murphy, C. H.....Bartow
Nicholson, L. B.....Lakeland
Poucher, Allen A.....Wauchula
Roberts, T. H.....Lakeland
Sanchez, B. H.....Plant City
Smith, H. Mason.....Tampa
Spengler N. L.....Tampa
Taylor, Joseph W.....Tampa
Watson, Edgar.....Lakeland
Watson, Herman.....Lakeland
Whitaker, H. E.....Tampa

GUESTS FROM F. M. A.

Gardner, J. F.....Winter Park
Jelks, Edward.....Jacksonville
Osincup, G. S.....Orlando
Pease, Charles W.....Bartow
Richardson, Shaler.....Jacksonville
Spiers, W. Henry.....Orlando

VISITORS

Diehl, E. H.....Dunedin
Holton, W. J., Jr.....Plant City
Nix, Harold G.....Tampa
Sanchez, Elliot.....Plant City
Woods, E. Bryant.....Tampa

WOMAN'S AUXILIARY—Members and Guests

Croley, Louise.....Plant City
Farrington, Mrs. Charles L.....Tampa
Holton, Mrs. W. J.....Plant City
Knight, Mrs. J. C.....Plant City
Nicholson, Mrs. L. B.....Lakeland
Poucher, Mrs. Allen A.....Wauchula
Sanchez, Mrs. B. H.....Plant City

ANNUAL MEETING
NORTH CENTRAL DISTRICT

The first annual meeting of the North Central Medical District (B) was held at Ocala, Wednesday, October 27 at the Harrington Hall Hotel. The total registration was 56. Of this number 39 were doctors who are members of the county societies in this district; 7 were visiting doctors from Duval County; 2 from Orange County; 2 from Marion County; 1 from Alachua County; 1 from Bradford County; and 1 from Pasco County. Firms having headquarters in this district, who exhibited at the Association's annual meeting, received an invitation to have their representatives attend this meeting.



This was the fifth annual medical district meeting during the year. There are seven county medical societies in this district with a total membership of 88. Sixty-four per cent of the entire membership was present at the district meeting. The Marion County Medical Society acted as host, with a Local Committee on Arrangements composed of Dr. T. H. Wallis, Chairman; Dr. R. C. Cumming; and Dr. R. D. Ferguson. The large dining room was ample to accommodate all who attended and the officers of the Harrington Hall Hotel extended every courtesy for the pleasure and comfort of the doctors and their guests. There was no registration fee and the only cost was 75c a plate for an excellent dinner.

Dinner was served at 6:30 p. m. and at 7:40 Dr. A. B. Albritton, Senior Councilor, called the meeting to order. Dr. R. E. Russell, President of the Marion County Medical Society, delivered the address of welcome. Dr. Edward Jelks, President of the Florida Medical Association, was then called upon and

before going into his outline of the activities of the Association, made a short response to the address of welcome. President Jelks, through his experience at the four previous meetings, contact with standing committees, and his work so far this year as the leader of the Association, brought to the gathering some very interesting and helpful information and suggestions concerning organized medicine in Florida. Dr. Shaler Richardson, Secretary-Treasurer and Editor of the Journal, then gave a brief address on the phases of the work pertaining to the Association's Journal and activities in the central office. Dr. W. McL. Shaw, Chairman of the Council, outlined the particular responsibilities of the councilors, explaining the purpose of the district meetings, and brought out very constructively, the value of the Council in the general program of the Association.

The presiding officer, Doctor Albritton, then recognized President-elect W. Henry Spiers. Doctor Spiers reviewed the history of organized medicine, naming some of the outstanding leaders in the state who carried on in their time faithfully and vigorously. He pointed out that the problems in their time were different from the problems now facing the leaders of organized medicine but if it had not been for their faithful activities, the profession would not be where it is today in organized medicine. Dr. A. H. Freeman, past president, was then recognized and responded briefly. Dr. Gilbert Osincup, Chairman of the Executive Committee, was recognized and in a very forceful manner emphasized the importance of meeting the problems of today with enthusiasm and courage. Dr. E. T. Sellers, Chairman of the Committee on Venereal Disease Control, was recognized and very briefly mentioned some of the activities of his committee.

Dr. George A. Dame, carry-over senator, was then recognized. Doctor Dame, in a very pleasing and forceful manner, brought a message concerning the relation of organized medicine to the state legislature. The group was very fortunate to have Senator Dame bring this message, of vital importance to every doctor in the state. He complimented the officers of the Florida Medical Association, stating that they are not only well qualified for their various tasks, but understand and put into effect the best possible methods. After outlining some of the approaches of the doctors to the legislature, which were made in a way to obtain best results, he very frankly explained to those present some of the reasons why medical bills so often fail in passage at the legislature. Senator Dame's timely remarks emphasized the importance and value of a district medical meeting.

Those who have been privileged to attend the district meetings so far this year feel that the district comprises an ideal number of doctors for a real get-together meeting for dissemination of information and planning activities to meet the problems of the day. The attendance at our annual meetings for the entire Association is too large to get the benefit of expression from the majority of those present. In a district medical meeting, however, the attendance is smaller and, therefore, an opportunity is given to everyone present to be heard. The officers of the Association hope that the inauguration of annual district medical meetings will bring a closer relationship between the members and their officers.

The next order of business was the selection of a meeting place for 1938. Invitations were extended from Ocala and Gainesville. A vote was taken and a majority cast for Gainesville. The meeting place for 1938 was then announced as Gainesville.

After a short recess, Dr. R. B. Harkness, Junior Councilor, called the scientific session to order. The first paper was read by Dr. R. D. Ferguson of Ocala on "Acute Conditions Within the Abdomen." The second paper, read by Dr. Edward Jelks of Jacksonville, was on "Some Experiences in the Diagnosis of Gastro-Intestinal Cancer." The third paper, on "Complications Following Cauterization of the Cervix," was read by Dr. J. M. Dell, Jr. of Gainesville. Doctor Harkness, who presided at the scientific session, expressed his deep appreciation of the splendid papers which had been prepared and presented. It was necessary to have the use of a projecting lantern for illustrating the papers and Dr. W. McL. Shaw of Jacksonville carried his personal equipment to the meeting for the convenience of those essayists who desired their papers illustrated. It was very generous on the part of Doctor Shaw to transport his equipment from Jacksonville to Ocala, see that it was properly

set up before the meeting, operate it during the session, and pack it up for transportation back to Jacksonville. This special service rendered by Doctor Shaw is another illustration of the untiring efforts of the officers of the Association.

REGISTRATION

Albritton, A. B., *Senior Councilor* ..... Wildwood
Harkness, R. B., *Junior Councilor* ..... Lake City
Thompson, Stewart, *Managing Director,* Jacksonville

MEMBERS

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FLORIDA EAST COAST MEETING

The Florida East Coast Medical Association held its Tenth Annual Meeting at the Hollywood Beach Hotel, Hollywood, November 12-13, 1937. The meeting was called to order by the president, Dr. E. B. Hardee of Vero Beach. The address of welcome was delivered by Dr. George S. McClellan, President of the Broward County Medical Society. Ten scientific papers were presented, as follows:

"Fractures of the Spine," M. Paul Travers, Miami.

"Clinical Significance of Asthma in Heart Disease," E. Sterling Nichol, Miami.

"Vaginal Approach to Stone in Lower Ureter," E. Clay Shaw and Jack A. McKenzie, Miami Beach.

"Some Observations on Hip Fractures," Charles B. Mabry, Jacksonville.

"The Diagnostic Value of the Neutralizing Function of the Stomach," Kenneth Phillips and A. Buist Litterer, Miami.

"Gonococcal Peritonitis of the Right Upper Quadrant," T. F. Hahn, DeLand.

"Protamine Insulin in the Treatment of Diabetes Mellitus," Louie M. Limbaugh, Jacksonville.

"Treatment of Poisonous Snake Bites," A. D. Amerise, Coral Gables.

"Stricture of the Rectum in Lymphopathic Venereum," Duncan McEwan, Orlando.

At eight o'clock the doctors, their wives and guests, were entertained in the Bamboo Room of the Hollywood Beach Hotel, at a banquet and dance. Dr. Ralph Greene of Coral Gables ably acted as toastmaster. Hon. Roe M. Fulkerson gave a very delightful and entertaining talk on "Bedside Manner." During and following the dinner there was dancing to the rhythmic music of the Hollywood Beach Hotel orchestra. Guests present were entertained by an excellent floor show.

Melbourne was selected as the convention city for 1938. The following officers were elected for the coming year:

President, Walter C. Jones, Miami; first vice-president, Elbert McLaury, Hollywood; second vice-president, Randolph Perdue, Miami; secretary-treasurer, T. C. Kenaston, Cocoa.

The Association stood in silence for one minute in reverence to Dr. G. C. Hardie of Fort Pierce whose untimely death occurred during the past year.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

The following papers constituted the scientific program at the regular meeting of the Dade County Medical Society, on November 5:

"The Problem of the Bleeding Uterus," C. Larimore Perry, Miami.

"The Routine Study of Fresh Vaginal Secretions in Obstetrics and Gynecology," J. Randolph Perdue, Miami.

"Trichomonas Infestations in the Male," Perry D. Melvin, Miami.

* * *

DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The regular monthly meeting of the DeSoto-Hardee-Highlands County Medical Society was held in Wauchula, November 12, with the following members present: Drs. McSwain, Peacock, Chandler, Bevis, Poucher, Weems, Spears, McKnight, Kirkpatrick, Kayton and Martin. Visitors included Drs. J. G. Lester of Lakeland and Dr. J. M. Philpot of Bowling Green. Doctor Lester was principal speaker and gave a very interesting report of several unusual cases, which he illustrated by x-ray films. Wauchula was chosen again as the place of meeting in December.

* * *

DUVAL COUNTY MEDICAL SOCIETY

The annual meeting of the Duval County Medical Society was held on the evening of December 7 at the State Board of Health Building, Jacksonville. Dr. J. Lunsford Boone assumed office as president. The election of officers resulted as follows: president-elect, Dr. Thomas A. Buckman; vice-president, Dr. B. F. Woolsey; secretary, Dr. George W. Croft; and treasurer, Dr. Alan Brown.

Members of the committees who will serve during his term in office have been appointed by Doctor Boone, as follows:

Economics—Dr. Thomas S. Field, chairman, and Drs. Stanley Erwin, E. T. Sellers, E. W. Veal, Harry Peyton, Frank Fort, W. G. Harris.

Entertainment—Dr. W. S. Manning, chairman, and Drs. Robert McIver, Robert May, Ferdinand Richards, Thomas Palmer, Kenneth A. Morris, John Lovejoy.

Program—Dr. B. F. Woolsey, chairman, and Drs. Raymond King, Karl Hanson, Thomas A. Buckman, C. W. Boyd, C. C. Mendoza, Alan Brown, and Doctor McIver, representing the entertainment committee.

Public Health and Legislation—Dr. Russell Dean, chairman, and Drs. E. B. Milam, Gordon Ira, Victor Hughes, S. E. Driskell, E. C. Swift, George W. Croft.

Public Relations—Dr. Louie Limbaugh, chairman, and Drs. J. G. Lyerly, Ben Manhoff, F. H. Schnauss, L. V. Tyler, J. W. Hayes, J. L. Borland.

Fraternal Relations—Dr. Banks Goodale, chairman, and Drs. H. D. Van Schaick, F. W. Kreuger, John Norwood, H. L. Brillhart, W. W. Kirk, L. N. Moe.

Certified Milk—Dr. Lucien Dyrenforth, chairman, and Drs. W. E. Ross, N. A. Upchurch, Luther Holloway.

Editorial—Dr. Webster Merritt, chairman, and Drs. F. G. Slaughter, John O'Dell, George W. Croft.

Dr. Edward Jelks was re-elected parliamentarian.

* * *

LAKE COUNTY MEDICAL SOCIETY

The Lake County Medical Society held its annual meeting on December 2, at which time the following officers were elected to serve for the coming year: President, H. T. Fenn, Mount Dora; Vice-President, W. G. DeVane, Groveland; Sec'y-Treas., W. L. Ashton, Umatilla. Delegates to Annual Convention, H. T. Fenn and LeRoy Oetjen.

* * *

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY

The annual meeting of the Leon-Gadsden-Liberty - Wakulla - Jefferson County Medical Society was held October 21 at Tallahassee. The following papers were presented:

"The Doctor's Responsibility in Cases of Fractures," Charles H. Watt, Thomasville, Ga.

"Therapy in Modern Psychiatry," W. G. Miles, Chattahoochee.

"Auscultation of the Abdomen," J. H. Pound, Tallahassee.

"The Review of Literature on the Sulfanilamides," F. T. Holland, Tallahassee.

"Case Reports," Henry E. Palmer, Tallahassee.

At the business meeting the following officers were elected to serve during the coming year:

President, W. D. Rogers, Chattahoochee; Vice-President, S. E. Wilhoit, Quincy; Sec'y-Treas., B. A. Wilkinson, Tallahassee.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

The regular meeting of the Pasco-Hernando-Citrus County Medical Society was held in Dade City, Thursday evening, November 18. Dr. H. L. Harrell of Dade City acted as host. Dr. J. N. Moore of Ocala was the guest speaker and presented a very interesting paper on the use of x-ray in the various treatments of pathological conditions and diseases.

During the business meeting which followed the scientific program, the society took action to endorse the antisyphilitic campaign conducted by the United States Public Health Service, with the understanding that the society reserves the right to censor all papers for newspaper publicity in the counties affected.

Inverness was selected for the next meeting, to be held on December 9, with Dr. Claude L. Carter acting as host. Members present were: Drs. J. T. Bradshaw, G. R. Creekmore, George A. Dame, S. C. Harvard, W. W. Jones, R. D. Sistrunk. Guests were Drs. W. H. Cox, H. L. Harrell, H. G. Holland, and J. N. Moore.

* * *

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society held its Fifth Annual Dinner Meeting at the Veterans' Hospital Facility, Bay Pines, on the evening of November 5. The following members of the Hospital Staff presented the scientific program: Drs. S. M. Wrenn, J. F. Mantell, W. P. Moore and O. N. Nelson.

The second semi-monthly meeting of the Society was held on November 19 at the Shrine Club. The scientific program consisted of a symposium on sulfanilamide, which was directed by Dr. R. H. Knowlton of St. Petersburg.

* * *

PUTNAM COUNTY MEDICAL SOCIETY

The regular bi-monthly meeting of the Putnam County Medical Society was held at the Marion Hotel, Palatka, at 6:30 p. m., December 7, 1937. The dentists and pharmacists were invited to attend this meeting. One end of the large dining room was partitioned off by portable screens and a very fine chicken dinner was served to those present. Following the delightful dinner, cigars and cigarettes were passed down the long table.

Dr. H. A. Johnson, president of the society, called the meeting to order and after the reading of the minutes by Dr. Emory Bell, the secretary, and regular routine business, President Johnson introduced the guest speaker, Dr. Edward Jelks of Jacksonville, who is president of the State Association. Doctor Jelks presented a very interesting paper on "Some Thoughts and Experiences with Diseases of the Heart." The essayist illustrated his presentation by the use of a blackboard and colored crayons. Appreciation of Doctor Jelks' contribution to the evening's program was evidenced by the extended discussion entered into by those present.

Members present were Doctors Johnson, Brantley, Gurganious, Ford, Rose, and Bell; dentists were Doctors Kysong, and Thornton; pharmacists, Doctors Brown, and Gross; from the State Association, Doctors Jelks and Thompson. There being no further business, President Johnson entertained a motion to adjourn until the next regular meeting on the second Tuesday of February.

* * *

VOLUSIA COUNTY MEDICAL SOCIETY

THE VOLUSIA COUNTY MEDICAL SOCIETY HAS JOINED THE GROWING LIST OF SOCIETIES WHOSE DUES FOR 1937 ARE 100% PAID. WITH A MEMBERSHIP OF 38, THIS SOCIETY HAS BEEN HEADED THIS YEAR BY DR. J. RALSTON WELLS, PRESIDENT; DR. HUGH WEST, VICE-PRESIDENT; AND DR. R. L. MILLER, SECRETARY-TREASURER.

At the November meeting of the Volusia County Medical Society, the following resolution was passed with reference to the recent death of Dr. J. J. Kindred:

"Whereas it has pleased God in His infinite wisdom to take unto Himself our beloved colleague, Dr. J. J. Kindred; and

"Whereas, his interest, his presence, and his counsel will be continually missed in our Society; be it

"Resolved, that we, the members of the Volusia County Medical Society, offer our profound sympathy and deep condolence to his bereaved wife, and be it

"Resolved, that a copy of this resolution be sent to his wife, spread upon the minutes of this Society and published in the Florida Medical Journal."

ABSTRACT DEPARTMENT

Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.

Chondromatosis of the Joints—Freund, Ernst, Venice, Fla., *Arch. Surg.*, 34:670-686, (April) 1937.

Chondromatosis of the joints is a rare condition, one which is more often diagnosed than actually occurs, due to misapprehension of the fundamental pathological changes which occur in this disease. To further the understanding of chondromatosis the author reports in great detail the pathological and clinical findings in three cases.

Chondromatosis clinically produces pain, limitation of motion, and swelling of a joint or joints, and on roentgen examination reveals joints containing few to many small round, calcified bodies. The relationship of the condition to infection or injury is not evident in the histories.

Histologically these joint bodies and the synovial membranes show first infiltration of homogeneous red material into the collagenous fibres, a production of cartilage in fibrous tissue. With infiltration of this cartilagenous material one also finds embryonal mesenchymatous tissue. In certain places along with these processes, a primitive process of ossification can be found, the osteoid tissue soon becoming calcified. Owing to the rapidity of production of young cartilagenous tissue and the confinement in the joint space, concentric arrangement and the formation of joint bodies occur. As the bodies become calcified the cartilagenous cells disintegrate, or if calcification is not extreme, a later resorption of cartilagenous material occurs.

The former idea that chondromatosis is a blastoma seems incorrect in the light of these studies, for if it were a blastoma one would expect to find within the synovial tissue small centers of hyaline cartilage from which "by autonomous proliferation" small chondromas would develop, instead of which is seen at first an impregnation of collagenous tissue by red embryonic cartilagenous material. Freund believes that the process of chondromatosis is more like that of myositis ossificans, which is now held by most authorities to be neither a tumor nor an inflammatory process. The conclusion is reached that chondromatosis is a "metaplastic hyperplasia of connective tissue," explainable by the close relation of synovia to cartilage.

A Study of 2,900 Chest Roentgenograms of BCG Vaccinated and Control Infants in Tuberculous Families—Kereszturi, Camille; Park, William H.; and Logie, Arthur J., New York City, Natl. Tuberculosis A., 1935, pp. 97-108.

The authors believe that the incidence of latent lung tuberculosis as diagnosed by chest roentgenograms among children under five years of age has not been fully studied. Emphasis has not been placed on the roentgen findings of young children because of the difficulty of interpretation of chest films in early childhood. Admitting the difficulties in diagnosis in children under five years old, the authors undertook the study of 2,900 chest roentgenograms among infants of tuberculous families. An attempt was made to answer the following questions:

1. What is the incidence of abnormal shadows in the chest roentgenograms of tuberculous contacts under five years of age?
2. Is the frequency of the abnormal roentgen findings influenced by BCG vaccination?
3. What is the prognosis of infants with tuberculous infection without roentgen or clinical evidence of disease in comparison with other similar infants who have clinical disease as demonstrated by abnormal tracheobronchial lymph node shadows or lesions in the lung parenchyma proper?
4. Finally, check the accuracy without clinical data of roentgen readings among children less than five years of age.

The roentgen examinations were made without clinical data in order to obtain unbiased readings and to study the limitations without other data. Eight hundred eighty-one cases roentgenogramed were grouped in three categories:

a. Children who were immunized by the Calmette vaccine who were members of tuberculous families.

b. Controls who were also members of tuberculous households.

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c. Children who had positive Mantoux tests who came from tuberculous families.

The result of these studies is shown in eight different tables. Table one shows the distribution of chest roentgenograms taken according to type of case and age; table two, the frequency of positive chest roentgenogram readings according to exposure or lack of exposure to tuberculosis; table three, the incidence of positive roentgen findings in the lungs of tuberculin positive children; table four, yearly frequency of positive chest roentgenogram readings; table five, correlation of positive chest roentgen readings with tuberculin tests; table six, type distribution of 49 positive chest roentgen readings in tuberculin negative children; table seven, incidence of primary type of reaction in the lungs of BCG vaccinated and control children; table eight, tuberculosis death rate of the children radiographed.

The following conclusions were made:

"1. 2,900 chest roentgenograms were studied on 881 children of tuberculous families.

"2. This represents 60.6 per cent of all the 1,453 children included in the BCG investigation.

"3. The ages of the children roentgenographed ranged from birth to five years.

"4. More children were studied in the younger age groups than in the older ones.

"5. The minimum number of chest plates taken was 1 per child, the maximum number 16, and the average number 3.3.

"6. 6.1 per cent of the cases showed abnormal mediastinal shadows and 6.9 per cent of them demonstrated parenchymatous lung lesions.

"7. Children who were exposed to open tuberculosis showed 8.2 per cent glandular enlargement and 10.5 per cent parenchymatous lung lesions.

"8. Children who were exposed to closed tuberculosis had an incidence of the mediastinal gland abnormality in 3.8 per cent, and parenchymatous lesions in 1.2 per cent of the cases.

"9. Children who came from tuberculous families, but were not exposed showed no parenchymatous lesions, and only 1.6 per cent abnormal gland shadows.

"10. The BCG vaccinated children and the controls did not show any appreciable difference regarding roentgen findings if all the cases were included. However, if only those cases were tabulated which became tuberculin positive either due to natural infection or due to the Calmette vaccination, the immunized children showed parenchymal lung lesion in only 4 per cent of the cases, whereas the non-vaccinated ones gave a frequency of 32 per cent of lung lesions.

"11. The analysis of the 201 positive chest roentgen readings in our study shows that in 35.8 per cent of the cases where gland enlargement was noted and in 22.1 per cent where parenchymatous shadows were read, the tuberculin test was negative.

"12. Most difficult to interpret, particularly in early infancy, were the widening of the upper mediastinum without calcification and the non-calcified hazy shadows in the lung parenchyma.

"13. Of 60 patients having positive tuberculin tests with parenchymal lung lesions, demonstrated by chest roentgenograms, 21 or 35 per cent died of tuberculosis.

"14. Among 464 non-vaccinated children, we observed 17 instances of unmistakable primary complex and 9 cases of mediastinal lymph node calcifications. Among the 417 vaccinated cases no definite primary complex and only one case of peribronchial lymph node calcification was found."

The broadcast on "Hypersensitive People" by Dr. S. C. Colley of Tavares, was published in the July, 1937, Journal of the Florida Medical Association. In the December, 1937, number of Science Digest, a condensed form was published under the caption, "Allergic People." This recognition of the Association's broadcasts over station WRUF at Gainesville reflects the good work of the Committee on Public Relations.

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HYGEIA CONTEST

Mrs. John H. Mitchell, our state Hygeia Chairman, sends this message to the county auxiliaries:

We are especially interested this month in the Hygeia Contest. The American Medical Association is donating $150.00 in prizes for our Woman's Auxiliary Hygeia Contest. This gives each County Auxiliary a grand opportunity to raise their Hygeia quota, as well as to win a $50.00 cash prize.

The special rate offered in December to physicians only, and Christmas rates given dentists, nurses and the public, should create enthusiasm and make December our largest subscription selling month.

We are glad to note that auxiliaries with a small membership have an equal chance of winning, to those with a greater number of members.

The $150.00 will be divided into three cash prizes of $50.00 each, namely:

Group I—Auxiliaries with a membership of 1 to 49 ..... $50.00
Group II—Auxiliaries with a membership of 50 to 199 ..... $50.00
Group III—Auxiliaries with a membership of over 200 ..... $50.00

Each group prize awarded will be based on the quota and the number of subscription credits secured. The quota of each County Auxiliary is the number of paid-up members in each auxiliary at the close of our fiscal year for 1936.

A new or renewal one-year subscription will count as one credit; a two-year subscription as two credits; a six-months' subscription as one-half credit. In the event of a tie, the county sending the largest number of two-year and



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three-year subscriptions will be awarded the prize. No county will be given a cash prize unless its auxiliary has secured at least twenty-five subscription credits. The time of the contest covers the period from December 1, 1937, to January 31, 1938.

This is a national contest and all county auxiliaries affiliated with the State Medical Society are eligible to participate. We hope that our state will be well represented in this contest and that at least one of the prizes will be awarded to a Florida County Auxiliary.

While we are anxious to win a prize, let's not forget the real issue—"The Good We Do" by placing Hygeia in reach of as many people as possible. When we note that last year $350,000,000.00 was spent on patent medicine and quack preparations, we are stimulated to put forth every effort possible to do something about it.

* * *

DADE COUNTY

The new officers of the Dade County Auxiliary, headed by Mrs. R. O. Lyell, president, began their term of office at the meeting on November 8.

Arrangements were made for entertaining the wives of Seaboard Air Line Surgeons convening there in November.

This auxiliary is continuing its splendid work and interest in tuberculosis by taking as its major project the prevention of tuberculosis by early diagnosis and prompt treatment. The sale of Tuberculosis Christmas Seals in the business district of Miami, Coral Gables and Miami Beach is one of the civic projects of the auxiliary.

Auxiliary plans were begun for the annual meeting of the Florida Medical Association which convenes in Miami on May 9-11, 1938, at the Columbus Hotel.

* * *

ORANGE COUNTY

The Orange County Auxiliary held its first meeting of the new fiscal year in the form of a luncheon meeting November 19, at the Colonial Orange Court Hotel.

Nineteen articles were turned in for the Needlework Guild, among which were sheets, pillowslips, spreads, and hospital gowns. These articles were specified for the use of the county nurses in their work. A pair of wool blankets were given to complete the bed which the auxiliary furnished last year to the tuberculosis unit of the County Home.

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Mrs. Charles Collins presided. The speaker, Roderick Dorsey, who was for a number of years a member of the Diplomatic Service, gave an interesting sketch on how medicine has developed through the ages in China, and spoke of the customs of the people. Five new members were welcomed into the auxiliary.

ADVERTISERS' NOTES

METRAZOL IN DENARCOTIZATION

The cardio-respiratory stimulant, Metrazol, is receiving considerable attention not only for emergencies during anesthesia, but for denarcotization procedures following surgical operations.

The plan which is frequently used is to inject 3 cc. of Metrazol intravenously and 3 cc. intramuscularly immediately after the close of the operation. A smaller dose, 1 or 2 cc., is given in one-half to one hour and repeated one hour later if indicated. Usually this dose does not awaken the patient, but is given with the idea of restoring the reflexes, then allowing the patient to sleep through the pain zone with the surgical anesthetic acting as a postoperative analgesic.

According to Hogan (Amer. Jour. Surg., 38:340, Nov., 1937), "Metrazol is a milder, more uniform, more effective means of accomplishing complete aeration of the lung than the use by the individual of the carbon dioxide-oxygen mixture with the attendant dangers of over-stimulation and laceration of the smaller alveoli." Hogan has observed that often the excursion of the thorax is increased before the intravenous injection of Metrazol is completed.

Further information on Metrazol and its use in combating depression from barbital derivatives, the opiates, asphyctic conditions, etc., will be sent upon request to the Bilhuber-Knoll Corp., 154 Ogden Ave., Jersey City, N. J.

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Jacksonville Meeting of the Southern Medical Association.—Without question, the recent meeting of the Southern Medical Association at Jacksonville, Fla., was the most successful and enthusiastic in the history of the organization. The attendance was very much larger than that of any previous meeting, and the formal orations and scientific papers were of a class that cannot be excelled. The deliberations were harmonious * * * of great benefit * * * to the welfare of humanity everywhere. * * * It is no invidious distinction to say that on the whole, taking into consideration the eminence of the authors and the importance of their subjects, the material now at the command of the JOURNAL surpasses in interest and practical value any similar accumulation of manuscripts it has hitherto published.

"The hospitality with which the Association was received by the physicians of Jacksonville and Duval County could not be surpassed. One enthusiastic speaker declared that it 'exceeded anything in the history of the world.' Banquets, receptions and auto rides were but a few of the items. A feature which was an improvement on previous meetings was the practical management of the exhibits made by persons and firms seeking patronage from the doctors. Under the supervision of Mr. C. P. Loranz, they were so arranged as to be presented in logical order and without confusion.* * * Lexington, Ky., is the place selected for the meeting of the Association next October. * * *

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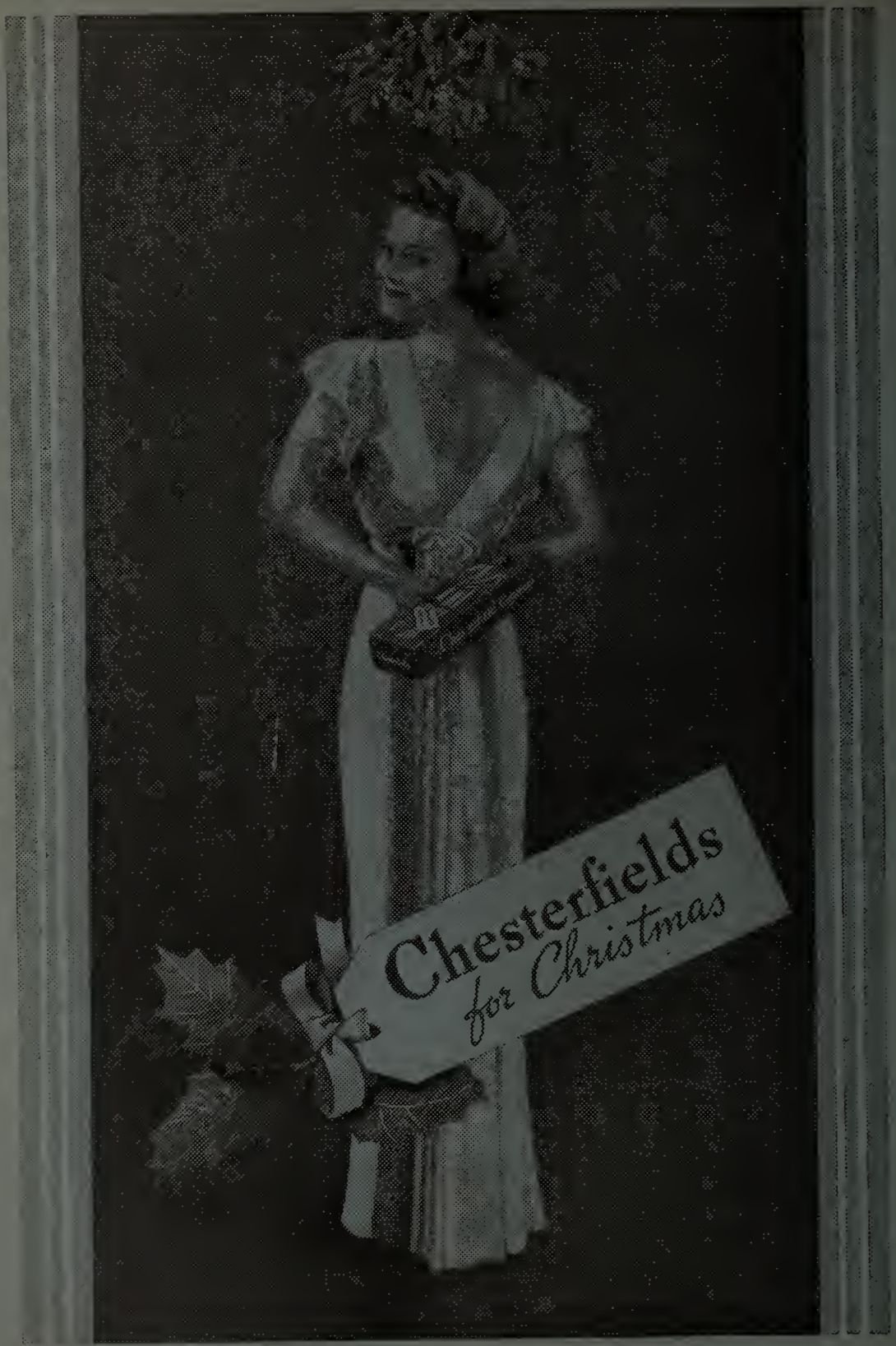


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American Medical Association, San Francisco, June 13-17, 1938.
Southern Medical Association, Oklahoma City, 1938.

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1a. 1935. J. Am. Med. Assn. 105, 1580.
b. 1934. The Vitamin B Requirement of Man, G. R. Cowgill, The Yale University Press, New Haven.

2. 1937. J. Am. Diet. Assn. 13, 195.

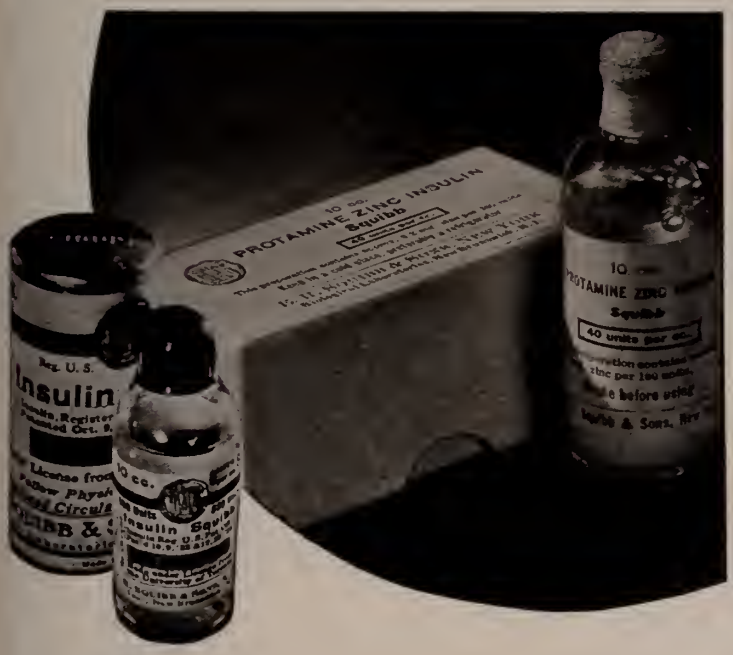
3. 1936. J. Nutrition 11, 383.
1934. Ibid. 8, 449.
1932. Ibid. 5, 307.
1932. Ind. Eng. Chem. 24, 457

This is the thirty-second in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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The swaddled infant pictured at right is one of the famous works in terra cotta exquisitely modeled by the fifteenth century Italian sculptor, Andrea della Robbia. In that day infants were bandaged from birth to preserve the symmetry of their bodies, but still the gibbous spine and distorted limbs of severe rickets often made their appearance.



A bambino from the Foundling Hospital, Florence, Italy,—A. della Robbia

Glisson, writing in 1671, described an ingenious use of swaddling bands — "first crossing the Brest and coming under the Armpits, then about the Head and under the Chin and then receiving the hands by two handles, so that it is a pleasure to see the Child hanging pendulous in the Air . . . This kind of Excercise . . . helpeth to restore the crooked Bones. . . ."

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SWADDLING was practised down through the centuries, from Biblical times to Glisson's day, in the vain hope that it would prevent the deformities of rickets. Even in sunny Italy swaddling was a prevailing custom, recommended by that early pediatrician, Soranus of Ephesus, who discoursed on "Why the Majority of Roman Children are Distorted."

"This is observed to happen more in the neighborhood of Rome than in other places," he wrote. "If no one oversees the infant's movements, his limbs do in the generality of cases become twisted. . . . Hence, when he first begins to sit he must be propped by swathings of bandages. . . ." Hundreds of years later swaddling was still prevalent in Italy, as attested by the sculptures of the della Robbias and their contemporaries. For infants who were strong Glisson suggested placing "Leaden Shooes" on their feet and suspending them with swaddling bands in mid-air.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

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IMPAIRED HEARING FROM CERTAIN DRUGS AND CHEMICAL POISONS*

H. Marshall Taylor, M.D.
Jacksonville

The selectivity of some drugs and chemicals for the auditory apparatus and their ability to cause deafness have been established by clinical and experimental studies. Also, injury to the auditory nerve from foreign substances circulating in the blood has been shown by these studies to occur oftener than with the other nerves of special sense. As many persons have a marked idiosyncrasy for certain drugs, in the study of nerve deafness of known pathology or etiology the consideration of idiosyncrasy to drugs is highly important.

That drugs may affect the auditory apparatus in a number of ways has been pathologically demonstrated. There may be a definite toxic action on the ganglion cells of the cochlea and the associated nerve fibers. Changes in the endothelium of the smallest capillaries may occur or contraction of the blood vessels of the internal ear may take place with resulting ischemia, lack of nutrition, and anoxemia, eventuating in a degeneration atrophy of the ganglion cells and the nerve fibers in the basal coil of the cochlea. A diminution in the endolymphatic pressure may also occur with a resulting collapse of the membrana Corti.

The cortical center of hearing may likewise be injured by drugs. Some have an affinity for the protoplasm, others for the nuclei of the cells. Animal experimentation in the study of deafness from drugs has perhaps centered more on the effect of drugs on the spiral ganglion cells and nerve fibers of the cochlea than on their effect on the cortical center of hearing. In collaboration with me, Dr. L. Y. Dyrenforth recently made spinal punctures on patients to whom 30 grains of quinine had been given for malaria. In these cases, he found quinine in the cerebrospinal fluid. Frequently at autopsy this drug has been found in concentration in the brain of newborn infants whose deaths were attributed to quinine used in the induction of labor. Sodium salicylate and alcohol also pass readily through the choroid plexus into the cerebrospinal fluid. The importance clinically of the presence of such agents as quinine, the salicylates and alcohol in this fluid has not been evaluated. Whether the drugs that pass through the choroid plexus into the cerebrospinal fluid also pass through the stria vascularis, which secretes the endolymph, and come in direct contact with the hair cells of the organ of Corti is a matter of interest yet to be determined.

*Read before the Sixty-fourth Annual Meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, 1937.

QUININE

Of all the drugs that cause deafness, quinine is the most important. This drug has a definite toxic action on the spiral ganglion cells and seems to have a special affinity for the external hair cells in the basal turn of the cochlea. It not only acts as a protoplasmic poison, but also as a vasoconstrictor. From the resulting ischemia, lack of nutrition and anoxemia there may follow a degeneration atrophy of the ganglion spiralis and Corti's organ. Wittmaack[1] concluded that quinine induces a hypotonia of the labyrinth, a diminution in the endolymphatic pressure with resulting collapse of the membrana Corti.

Quinine is frequently used therapeutically as an abortifacient, in the induction of labor and in diseases concurrent with pregnancy. According to Nicloux,[2] the human placenta acts as a dialyzer of drugs present in the maternal blood, and a crystalloid substance such as quinine, passing through the epithelium of the placental villi into the fetal circulation, may be found there in relatively the same strength as in the maternal circulation.

The use of twilight sleep furnishes evidence that the fetal tissues react to drugs in the same manner as the maternal tissues. Because of the respiratory depression of the newborn child its use has been largely abandoned in the practice of obstetrics. Numerous cases of congenital morphinism furnish further evidence that drugs pass from the mother to the

child through the placenta. Pettey[3] found that the newborn baby of a mother who is addicted to morphine or opium is as much an addict as the mother, for the child's blood and tissues are as fully saturated with the narcotic as are hers. He stated that every child born of a mother using opium should be given an opiate for the first three days after birth and appropriately treated for narcotism thereafter.

Quinine was found in the urine of 16 of the 17 babies examined by Dilling and Gemmel[4] after it had been given the mothers to induce labor. They reported finding the drug in the urine of the fetus six to twelve hours after the last dose had been administered to the mother. They observed that a concentration of quinine which may be toxic to the fetal tissues may persist in the fetus many hours after the wave of secretion in the maternal urine has subsided, owing probably to the slow return of the drug to the maternal circulation or to inability of the fetal kidneys to excrete it in such a concentration.

Regnier[5] stated that quinine was found in the blood and all the organs examined, including the brain, of a human fetus of 4½ months forty hours after the mother had taken 1.50 grams of quinine sulphate. He further stated that the concentration was comparatively high in the blood and higher in the brain than in the liver. In a case which resulted in a fetal death from quinine given the mother, King[6] found appreciable quantities of the drug both in the brain and in the urine of the fetus.

The literature is replete with reports of cases of deaf mutism that have been attributed to poisons in the mother's blood in diseases concurrent with pregnancy, such as rheumatic fever, influenza, and malaria. Yet little thought has been given to the fact that massive doses of drugs which cause nerve deafness are frequently prescribed to expectant mothers. In recent experiments in which he gave quinine and the salicylates to pregnant animals, Covell[7] found similar but more profound lesions in the hair cells of the organ of Corti of the fetal guinea pig than those of the adult animal.

When administered in the early months of pregnancy, drugs that cause nerve deafness may jeopardize the ear of the unborn child. According to Doctor Streeter[8] of the Department of Embryology of the Carnegie Institution of Washington, the spiral ganglion in the human embryo is recognized between the sixth and seventh week, and by the ninth week the cochlear nerve is definitely laid down, having its main characteristics, but it does not have its final myelinization until the last month of fetal life.

The presence of deafness at birth does not necessarily indicate that the condition is due to some hereditary defect, for it may result from injury to the organ of hearing in the course of the child's intra-uterine life. This type of deafness should, therefore, be classified as deafness acquired in utero, not as hereditary deafness. The prevention of deafness should, then, begin with the prenatal life of the child, and that would necessarily include the proper care of the expectant mother.

That the otologist and the obstetrician have in the past ignored the significance of prenatal medication in infant deafness may be due to the difficulty of early diagnosis. A child must be from 2½ to 3 years old before a diagnosis of nerve deafness can be made, and by that time the prenatal history has generally been dismissed. If the otologist in obtaining the history of each child showing a nerve deafness will inquire carefully into the history of drugs administered to the mother during her term of pregnancy, the etiology of a number of perplexing and otherwise unexplained cases of nerve deafness may be solved.

Quinine should be prescribed with the utmost caution for those persons who have a hereditary tendency to deafness and to early atrophy of the auditory nerve. It would seem that such medication might easily cause an early onset of deafness and a more rapid degeneration of the terminal filaments of the eighth nerve. In my opinion quinine is definitely contraindicated for the pregnant woman with a family history of deafness. Wilson[9] stated: "It is undoubtedly true that many of us disregard the action of drugs on susceptible individuals and on the unborn child. The more I see of progressive deafness, including otosclerosis, the more I am impressed with the deleterious effect of poisons carried by the circulation. Heredity counts undoubtedly,

but circulatory disturbances supply the match to the gunpowder."

SALICYLATES

Many persons are highly sensitive to the action of the salicylates and on taking them may develop a slow weak pulse, a subnormal temperature, dyspnea, dimness of vision, hissing and roaring sounds in the ear, and deafness. For severe degenerative changes to be produced in the auditory apparatus from the salicylates there must be a definite idiosyncrasy for them as it is well known that many persons may take massive doses of these drugs without experiencing any disturbance of hearing. Permanent deafness may occur as a result of the use of the salicylates but not so frequently as from quinine. Deafness from their use usually improves after their discontinuance but does not always disappear.

The chief pathologic change in the auditory apparatus in poisoning from the salicylates is found in the nerve cells of the spiral ganglion. Wittmaack[1] found changes in the form of the cells, changes in and in some instances complete disappearance of the Nissl bodies, and in the more sensitive cases changes in the nucleus.

The possibility of the effect on the cortical center of hearing must also be borne in mind in the administration of these drugs. Loberg[10] reported that sodium salicylate given to normal persons in doses of 6 grams daily for six days was regularly found in the cerebrospinal fluid. To determine whether this drug passes through the stria vascularis into the ductus endolymphaticus and bathes the hair cells of the organ of Corti, presents an interesting field for research. The fact that the salicylates are found in the cerebrospinal fluid suggests such a phenomenon.

The continued use of these drugs, particularly in children in the treatment of rheumatic fever and the exanthemata may cause an impairment of hearing. It seems logical to assume that the deafness often attributed to the toxemias of these diseases may sometimes be due to the indiscriminate and excessive use of these drugs that are known to cause nerve deafness.

The possibility of damage to the fetal ear following the prolonged administration of the salicylates to the expectant mother cannot be ignored. Porak[11] reported finding sodium salicylate in the urine of infants in cases in which this drug had been given to the mothers thirty minutes before delivery. He stated that the concentration was greater several hours after birth than at birth and that it was found in the urine for as long as three days. The fact that drugs affect mother and child alike is sufficient evidence that drugs which cause nerve deafness should always be administered with caution to the expectant mother.

ALCOHOL

Alcohol evidently has less affinity for the eighth nerve than other poisons such as quinine and the salicylates. It also has less affinity for the auditory nerve than for the optic nerve for it is not so frequently affected in alcoholic patients. In most of the cases of deafness from alcohol the onset is sudden, deafness not infrequently developing within a few hours. Both ears are as a rule involved; tinnitus often persists for long periods of time, and the occurrence of vertigo indicates that the vestibular portion is somewhat though not as markedly involved as the auditory portion of the eighth nerve. Prognosis is doubtful. Complete abstinence from alcohol is the most important factor in treatment.

Animal experimentation showed that alcohol seems to reserve its selective action for the nuclei of the hair cells of Corti's organ, particularly in the basal coil, with only slight similar alterations in the hair cells of the vestibular apparatus.

Alcohol is one of the drugs that readily passes into the cerebrospinal fluid, and in alcoholic intoxication a larger quantity is found in the brain than elsewhere in the body, the hearing center thus being exposed to a relatively large percentage of the poison. As the stria vascularis, which secretes the endolymph, seems to be analogous to the choroid plexus, which secretes the cerebrospinal fluid, it would therefore be of interest to determine whether or not alcohol may find its way into the endolymph as it does into the cerebrospinal fluid. Barany and Rothfeld[12] concluded that disturbances of equilibrium in alcoholic intoxication have their origin in the cerebellar cortex.

Wade[13] reported five cases of deaf-mutism that were attributed to chronic alcoholism in

the mother. In his experiments on women in labor, Nicloux[2] gave alcohol in milk an hour before delivery of the child and was able to demonstrate it in the blood of the umbilical cord in practically the same concentration as in the maternal blood. In reporting experiments with alcohol and sodium salicylate, this author stated that the quantity in the fetal blood is always proportionate to the quantity in the maternal blood. The danger to the fetal ear in cases of chronic alcoholism in the expectant mother cannot be ignored, particularly so because the cochlear nerve does not have its final myelinization until the last month of fetal life.

TOBACCO

A number of reports of impairment of hearing caused by tobacco occur in the literature. The symptoms are those of nerve deafness, often with associated disturbances of equilibrium, and in the less severe cases hearing tests are often negative. Symptoms usually disappear if the use of tobacco is abandoned. Pharyngitis, so common in smokers of tobacco, and the constant irritation of the mucous membranes of the nasopharynx and the eustachian tubes that occurs in heavy smokers, have in the past been suggested as causing symptoms of the middle ear without producing any actual toxic effect of the tobacco on the ear. More recently, cases with evidence of damage to the inner ear have been reported.

In his series of cases in which tobacco was used excessively, Delie[14] found deafness the chief symptom, and it was especially severe in young patients with otosclerosis. He felt that the excessive use of tobacco should be avoided by persons with any disease of the ear, particularly by young persons with beginning otosclerosis or hereditary tendency to deafness. He concluded that tobacco acts by stimulation of the sympathetic nerves, which results in an anemia in the auditory nerve and especially in the ganglia and nerve fibers of the cochlea, the altered circulation finally leading to faulty nutrition of the nerve with resulting degenerative changes. Referring to Delie's theory of the mechanism of the action of tobacco on the eighth nerve, Gy[15] noted that the direct effect of tobacco on the blood vessels should not be overlooked; he concluded that tobacco causes a true trophoneurosis, which results in atrophic neuritis of the auditory nerve.

Otological findings in a series of cases of toxic amblyopia resulting from the excessive use of both alcohol and tobacco, reported by Carroll and Ireland[16] pointed to islands of deafness comparable to the island defect in the visual field. As the average loss of hearing for the spoken voice in these cases was only 8 per cent, all were not aware of their deafness, but a considerable number of these patients showed a perceptible reduction of useful hearing. Since the ophthalmologic lesion is found in the retinal ganglion cells and the spiral ganglion cells and the ganglion cells of the retina are functionally and anatomically similar, these authors concluded the otologic lesion occurs in the spiral ganglion cells.

The animal experimentation of Schroeder and Hinsberg[17] showed changes in the cells of the spiral ganglion due to tobacco that were similar to changes in other nerve tissues, including the brain. Other experiments on animals showed injury to the cells of the vestibular ganglion. Kostencki,[18] recently reporting experiments on rabbits, concluded that nicotine acts on the entire vascular system of the hearing apparatus, including both the central and the peripheral portions, while alcohol exerts its toxic effect only on the central portion.

ARSENIC

With the advent of salvarsan, arsenic has come into prominence as a drug that may affect unfavorably the auditory function. Deafness and tinnitus have often been reported after its continued use. Animal experimentation has shown definite changes in both the vestibular and cochlear branches of the eighth nerve following its administration. Arsenic is one of the drugs that not only has effect on the ganglion cells but also Reissner's membrane, which may change the endolymphatic pressure. Miyamote[19] sectioned the internal ear of thirteen guinea pigs after having given them toxic doses of atoxyl, an arsenic preparation. In six of these animals there was marked degeneration of the epithelial layer of the stria vascularis with a sinking in of Reissner's membrane, resulting in narrowing or complete obliteration of the lumen of the cochlear duct. This finding the author at-

tributed to failure of the normal secretion of the endolymph. In all but one of the animals in which the changes described in the stria vascularis were present, the ganglion cells and Corti's organ also showed advanced changes.

The question of the effect of salvarsan on the auditory nerve is still open. Evidences of injury to this nerve have been noted in cases of syphilis under treatment with salvarsan, and the question arises whether the injury results from the effect of syphilis or from salvarsan. There is, however, some evidence that this drug, under conditions not well understood, may have a toxic action on the auditory nerve as well as other nerves. A few cases of injury to this nerve have been reported when salvarsan was used in non-syphilitic cases. Injury to it from neosalvarsan has not been reported.

LEAD

Of the industrial poisons that may affect the ear lead is one of the most important. It is known to have a toxic action not only on the nerve parenchyma but also on the blood vessels. Changes in the latter appear to play the chief role. There is some difference of opinion as to whether deafness resulting from lead poisoning is of central origin, due to vascular changes or the result of direct effect on the cells of the spiral ganglion. The fact that, as a rule, there is a diminution in hearing for the high notes points to a destruction of the cells at the basal turn of the cochlea. It is doubtful whether either the otologist or the internist has given sufficient attention to lead poisoning as a possible cause of nerve deafness.

PHOSPHORUS

Another one of the industrial poisons that produces deafness is phosphorus. Poisoning from this substance has long been observed to cause tinnitus, vertigo and deafness. This condition is frequently found in workmen exposed to its fumes in making friction matches. Experiments with rats and mice poisoned by phosphorus showed circulatory disturbances in the region of the temporal bone but no necrosis of the bone itself. Beck[20] found evidence of changes in the cells of the spiral ganglion in rabbits poisoned by this element. Nissl[20] in his studies of its effect on the cells of the brain found primary changes in the protoplasm rather than the nucleus of the cell, as was the case in the spiral ganglion cells in Beck's experiments with it.

CARBON MONOXIDE

Vertigo, tinnitus and deafness have been noted as symptoms of acute carbon monoxide poisoning. This type of poisoning is usually the result of inhaling illuminating gas and is due to the carbon monoxide content of the gas. Deafness from this cause is usually temporary, but permanent impairment of hearing has not infrequently been reported. It seems to be the concensus that carbon monoxide may cause changes in both the cochlear and vestibular branches of the eighth nerve and also injure the vestibular nucleus.

Rutenberg,[21] reporting experiments on mice, guinea pigs and cats poisoned by inhalation of carbon monoxide, stated that a study of microscopic sections of the inner ear, stained with hematoxylin-eosin or Weigert's stain, showed some hemorrhage in the scala tympani and the inner border of the lamina basilaris membranacea and slight hemorrhage in the scala vestibuli, but no other changes either in the cochlea or in the vestibular apparatus. Ruttin[22] reported three cases of deafness from acute carbon monoxide poisoning. In one there was tinnitus and slight loss of hearing with diminution of bone conduction indicating a cochlear lesion. In another, deafness was much more marked, being total on the left side with a negative Rinne's test and the interval much shortened in Schwabach's test. In the third case deafness was complete. In all there were disturbances of the vestibular reactions; in one they were entirely abolished. He concluded that carbon monoxide gas acts on the cochlear and vestibular ganglia.

CARBON DISULPHIDE

A temporary deafness, vertigo and tinnitus are not infrequent in carbon disulphide poisoning, and auditory hallucinations also occur. This type of poisoning is frequently seen among workmen in the rubber industry. The deafness is usually transitory and disappears after the subsidence of other toxic symptoms.

OIL OF CHENOPODIUM

Oil of chenopodium is used as an anthelmintic, particularly in the treatment of the Ascaris lumbricoides. It continues to retain its popularity in some sections of this country. Deafness from this drug has frequently been reported. It is associated with other toxic effects of the drug, such as tingling in the feet and hands, severe headache, dizziness, vomiting, nausea and occasionally convulsions. It varies from slight impairment of hearing to a complete bilateral deafness which, in some cases, becomes permanent. The onset of the deafness is rapid, occurring within two hours in severe cases.

It has been claimed that nearly one-third of the patients given oil of chenopodium in therapeutic doses show some disturbances of hearing. A comprehensive review of the American and European literature revealed no record of animal experimentation to determine what part of the auditory apparatus the oil of chenopodium affects. There is ample evidence, however, in clinical cases to show that the deafness is of the type affecting the internal ear. Suzuki[23] cited several Japanese authors whose experiments showed that this drug damages the spiral ganglion cells primarily and secondarily the nerve fibers of Corti's organ.

MERCURY

Mercurial poisoning occasionally causes disturbances of the inner ear and Ménière's symptom complex. Wyss[24] reported the cases of two chemists who suffered from chronic mercurial poisoning and were both deaf and blind before death. Several observers have reported symptoms of labyrinthine involvement and deafness associated with this poisoning. When mercury is used in the treatment of syphilis the question arises, as with salvarsan, whether or not any involvement of the auditory nerve is due to syphilis or the drug.

MORPHINE

Infrequently tinnitus and deafness occur after the subcutaneous administration of morphine. This drug is recognized as among the drugs which may, though rarely, have a deleterious effect on the auditory apparatus. This effect is manifested by auditory hallucinations, tinnitus and loss of hearing. Politzer[25] listed morphine among the drugs that may cause deafness.

ANILIN DYES

Numerous authors have reported deafness from poisoning by anilin and anilin dyes. It may be accompanied by tinnitus, often annoying and persistent, and vertigo, which are to be regarded as of central origin in the opinion of Beck.[20] This condition is attributed to the toxic action of the methemoglobin formed by anilin.

Other poisons that form methemoglobin also may cause pathologic changes in the eighth nerve. Deafness from this cause is characterized by a decrease both of air and bone conduction with a positive Rinne's test.

Of particular interest is poisoning by paraphenylendiamine, a derivative of anilin used in hair dyes, which produces labyrinthine symptoms. In two of the eighteen cases reported by Laurens[26] the onset of symptoms was rapid; vertigo, marked tinnitus and some diminution of hearing by air conduction following soon after application of the dye. In the others it was more gradual, occurring after prolonged use. Tinnitus, sometimes accompanied by attacks of vertigo, especially after fresh application of the dye, and progressive loss of hearing resulted. The deafness was characterized by diminution of both air and bone conduction with a positive Rinne's test, the symptoms in many respects resembling those of otosclerosis. Some of these cases presented general symptoms indicative of poisoning, such as neuralgic pains, headache and weakness.

A fur dyed with paraphenylendiamine and worn almost daily was the cause of a case of poisoning by anilin reported by Watson-Williams.[27] Tinnitus, at first occasional, became incessant and was accompanied by vertigo: severe nerve deafness also developed. In about ten weeks after the fur was discarded the symptoms disappeared.

SUMMARY

As has been clinically, experimentally and pathologically demonstrated, some drugs and chemicals have a selective action for the auditory apparatus. They may cause deafness and may also injure the cortical center of hearing. Idiosyncrasy for drugs, peculiar to many persons, may be an important factor in determining the cause of nerve deafness. Since the placenta is permeable to drugs capable of causing nerve deafness, the administration of such drugs during pregnancy may

endanger the ear of the unborn child. In this particular, quinine is the most important of these drugs for it is used frequently in the induction of labor, in the treatment of diseases concurrent with pregnancy and as an abortifacient. In addition to quinine, chief among the drugs causing nerve deafness, the salicylates and alcohol are often causative agents: less frequently are tobacco, arsenic, lead, phosphorus, carbon monoxide, carbon disulphide, oil of chenopodium, mercury, morphine and anilin dyes. Drugs and industrial poisons capable of damaging the auditory apparatus deserve greater consideration and more careful study as etiologic factors of deafness.

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DISCUSSION

Dr. H. Mason Smith, Tampa:

Doctor Taylor's paper offers satisfactory explanation of the background of many clinical symptoms and problems that have been met by neurologists and psychiatrists for years. It is probably in the neurologist's office that the effect of toxins which have a neuro-affinity is most often seen.

It has been my privilege to observe several cases of deafness and dizziness following malaria in the treatment of which massive doses of quinine had been administered. Many patients with this disease have experienced psychotic episodes with auditory hallucinations. These symptoms have been regarded as caused by the malaria, but with Doctor Taylor's work on the subject, we can now appreciate that the quinine has been a contributing agent. Numerous cases have come under my observation in which carbon monoxide poisoning has also precipitated psychotic episodes with auditory hallucinations.

Probably the toxins that have the greatest affinity for nerve tissue are the arsenical compounds, especially tryparsamide, which has a predilection for the optic nerve. The administration of tryparsamide has resulted disastrously in causing complete atrophy of the optic nerve in many cases. Before this drug is administered, a careful examination of the visual field should be made in each case, and if there is any defect in the field, tryparsamide

is contraindicated. In my experience, neither mercury nor bismuth has produced neurological or phychiatric symptoms in the treatment of syphilis, and for that reason in practically all advanced cases treatment is started with one of these drugs and iodides.

In his paper Doctor Taylor has brought out many points not formerly considered sufficiently important for serious consideration as etiologic factors, which have been the source of a great deal of neurological and psychiatric trouble. Many psychotic conditions are traced to nothing more than the use of some toxin administered in the treatment of another disease. This paper gives a pathological background for many otherwise unexplained conditions which have been encountered in my practice.

Dr. A. K. Wilson, Jacksonville:

You have just heard a very interesting paper by Dr. H. M. Taylor, and one which deserves consideration.

The cochlea, or organ of hearing, is a comparatively recent addition to the animal organism and has not the power of resistance or regeneration after destructive injury, as the older organs have. The liver, for instance, has greater resistance and will reproduce its tissue after destruction by 80 per cent of its original volume. The cochlea varies in size according to the development of the animal in the geological scale. In the human being it consists of two and one-half turns, and would measure about 28 mm. in length. The cochlea of the chicken, I found by personal dissection, measures only about 3 mm. in length and is not a conch-shaped body but is a straight cylinder.

Thomas Willis in the seventeenth century established the fact that the organ of hearing was in the cochlea. The anatomists of that day thought that the cavity of the cochlea was filled with air, but Cotugno in 1760, after dissecting fresh cadavers, discovered that the cochlea contained liquid rather than air.

It is hard to believe that out of 50,000,000 public school children, we have 3,000,000 hard of hearing, and 60,000 deaf children. We physicians should discourage the use of any drugs which may impair the function of hearing when other means are available. Quinine, for instance, has not only produced damage to hearing, but total blindness as well. Hydrotherapy should be prescribed more ferquently rather than cold tar preparations to control temperature, especially in those patients who are too young to give alarm about toxemia of the cochlea.

I, myself, have suffered with an acute toxemia of the cochlea, which came on twelve hours following the ingestion of about twenty grains of aspirin taken for a headache. The symptoms, tinnitus or noises and diminished hearing, lasted forty-eight hours. Fortunately, however, the inflammation was not so great as to destroy the organ of Corti of the cochlea.

Dr. T. Z. Cason, Jacksonville:

I think it is very apropos that this should be brought before a general group. One thing I wish to bring out: There has not been made a differentiation between the drug which causes deafness because of the drug and the excessive use of the drug, and the drug to which the individual has an idiosyncrasy as in the case of quinine.

After Doctor Taylor became interested in this subject, I investigated a family of six children. Three of them were deaf and three could hear perfectly and I questioned the mother at length. In all three instances, the children who had become deaf had been given quinine, and had an idiosyncrasy to quinine. We know, then, that these children had an idiosyncrasy to quinine. We also know that we can give many people large doses without any disturbance of their hearing.

With reference to the drug itself, I suspect strongly that oil of chenopodium, regardless of whether the person has an idiosyncrasy or not, will produce deafness. Kantor devised a method of giving oil of chenopodium through the tube into the duodenum. With reference to the patient mentioned by Doctor Taylor, I feel quite sure that the tube must have slipped back into the stomach. The child has some permanent deafness. Therefore, I think that oil of chenopodium was responsible for the deafness and not an idiosyncrasy on the part of the child. I agree with Doctor Taylor that oil of chenopodium should not be used, particularly in large doses.

Dr. M. A. Lischkoff, Pensacola:

Doctor Taylor brought out the important reason why the cochlear nerve is less resistant

than the vestibular nerve. He showed that it was anatomically different. The cochlea, as you know, is developed much later in the scheme of evolution than the vestibular branch.

I do not think that you would be interested in the method of the action of drugs, but after listening to the discussion, I realize that you are interested more than I first thought. You, as general men, are most interested in the results of medication.

Covell, in June, 1936, reported his studies on the prolonged administration of quinine and the salicylates in guinea pigs. Certain changes in the cochlea took place; they were in the nature of a protoplasmic poisoning of the cells. He found that when he gave quinine to pregnant guinea pigs, the cochlea of the fetal ear was more damaged than the adult animal.

I remember about a year ago, a small child was brought to my office who had taken quinine for previous malaria. He had taken it for a few weeks and was extremely deaf. The tuning forks showed a hearing loss with the c4, and the audiogram showed the loss in the upper scale. He complained of severe roaring in both ears. We treated him with doses of medical diathermy on the theory that the heat would be reflected to the deeper structures and improvement in the circulation of the ear would cause the ear to improve, and most of the hearing was restored. This happened just after the ingestion of the quinine. Naturally, we do not know whether some of the effects would have worn off. This encouraged us. We have used diathermy in the treatment of deafness after scarlet fever and in middle ear deafness (which is not under discussion here). We have secured much better results from that than anything else so far.

This is a very timely subject, not only to the otologist but to the general man and it should make us cautious before prescribing drugs that might result in impaired hearing. It may not be amiss to hope that sensitization tests be done to find out who can and who cannot assimilate these drugs.

We are certainly grateful to the author for bringing this to our attention and for the clarity and interesting manner in which he presented it.

TRAUMATIC SURGERY*

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INTRODUCTION

The rapid development of industry in general and the increasing incidence of automobile accidents has given the subject Traumatic Surgery an added importance everywhere. An additional factor is the frequency of injuries in sports and in the home, for next to those occurring in industry the greatest number of minor accidents occur in the home.

Industrial accidents handled through workmen's compensation comprise a major portion of traumatic work and emphasize its importance, because the cost of insurance is based upon the amounts paid out for medical care and disability payments. This factor places definite responsibilities on:

First:—The employee, to report immediately any injury which has the possibility of becoming serious. These should include extensive abrasions, deep lacerations, puncture wounds, sprains severe enough to cause continued pain and all more extensive injuries. Delay may mean the difference between a simple or complicated wound.

Second:—The employer, to select for his work surgeons equipped, qualified and sufficiently interested in that type of work to render an injured employee the same service given under similar circumstances to a private patient. Minor injuries of all sorts are likely to require considerable time and study and usually come to the doctor during busy office hours. Nevertheless immediate and careful treatment is imperative if complications are to be avoided.

Third:—The doctor, to handle each case with proper care and consideration, striving toward a good anatomical and functional result within the shortest possible time. In industrial work this has an important bearing on the economic factor involving both the wage earner and the employer.

It is the purpose of this paper to discuss minor injuries, or those seen in the office and emergency room of the hospital, for the reason that very little stress is laid upon such

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cases in our literature and scientific meetings. It is hoped also to inspire better average treatment in these cases by calling attention to some of the most common errors and by offering a few suggestions on treatment of the kind of cases most frequently seen.

SOME COMMON ERRORS

The first thought in treating puncture wounds usually is the danger and prevention of tetanus. Important as this is it often takes undue precedence over the prevention of infection in the local wound. It is too frequently the practice to dash a little iodine on the external wound, put on a dressing, give 1500 units antitetanic serum and discharge the patient. Most of these wounds are in the feet due to nail punctures and potentially infected and such treatment has no more value than the old-fashioned "fat meat" poultice. The writer has seen a number of cases of secondary infection following such careless methods.

Lacerated wounds are often closed by taking a few stitches hurriedly through all layers. This is a vicious practice especially when the wound is irregular in outline, or has beveled edges, or maceration of the tissues. Such technique would not be dreamed of in closing an operative wound and there is no reason for it in the accidental wound. In the absence of infection the wound would heal but crushed tissues do not heal by first intention and only a wide, ugly and sometimes painful scar is to be expected.

Poor preparation of the accidental wound with improper debridement of devitalized tissues before repair is one of the principal causes of slow or poor healing, because such devitalized tissues make excellent culture media for pathogenic bacteria which retard the natural processes.

Tightly tied sutures are always uncalled for. Stitches have no direct part in the healing process except to hold the edges in approximation so the proper organization of blood and lymph elements can take place. This is often forgotten in the haste of closing wounds and when the postoperative swelling occurs the sutures may be found cutting through the skin. Also it must be remembered that it is not always possible to determine the actual extent of tissue damage at the time of the accident.

Except rarely, the secondary repair of tendons is made necessary by a lack of proper diagnosis at the time of injury, and is most often seen in deep cuts about the hand and wrist, where the tendons are very elusive when severed. It is most important in these injuries to test the functions of fingers and wrist before repairing the wound. The diagnosis is sometimes difficult and may require considerable time and patience due to the tendency of long tendons to retract. It often becomes necessary to enlarge the original wound in order to locate tendon ends, and by no means should a wound be closed until the tendon ends are located and sutured together.

The minor accidental wounds should be followed to the point of complete healing the same as any other for in no other way can the surgeon observe the progress of the case and know that the end result is what was to be desired. A partially healed wound is a source of danger from delayed hemorrhage, late development of infection and other complications. Satisfactory treatment includes personal supervision until the patient can be discharged as cured.

Painful manipulation during suture of a wound or reduction of a minor fracture may destroy the confidence of the patient and lose his valuable cooperation in handling the case. Local anesthesia should be used to insure the proper degree of comfort to the patient and establish confidence and respect toward the surgeon. It will enable one to do a better job and also prevent a tendency towards hasty or careless treatment.

SUGGESTION FOR TREATMENT

For treating nail puncture wounds radical treatment applied to all cases gives best results, and is used as follows:

The foot, or other part, is cleansed with soap and water and benzene, or ether and alcohol and is then painted with tincture of iodine or merthiolate, following which clean or sterile towels (when available) are draped about the wound. The skin and subcutaneous tissues are infiltrated with novocaine, requiring one or two cubic centimeters. Then an incision is made about one-fourth to one-half inch long, to expose the nail tract and allow removal of foreign particles, and in deep or very dirty wounds is to be followed by irri-

gation with normal saline or peroxide of hydrogen. Tincture of iodine is then applied directly into the enlarged wound on a sterile cotton pledget, the pledget removed and a small wick of narrow iodoform gauze packed lightly into the wound. A dressing of 10% ichthyol ointment is applied and the patient given 1500 units of tetanus antitoxin except in cases where it is refused. The dressing is antiseptic and astringent. At the first subsequent dressing in twenty-four to forty-eight hours the wick is removed and the wound usually found clean and dry and not productive of pain. In a large number of the smaller wounds the patient can be discharged with instructions to remove the dressing in forty-eight hours when the wound is found completely healed.

In the past three years this treatment was used in 88 cases, which required a total number of 164 subsequent dressings, an average of a little less than 2 for each case. There were only two cases of secondary infection in the series; none of tetanus.

The proper treatment of accidental incised wounds is thorough preparation, antisepsis and anatomic approximation of the tissues. If the incision has been at an acute angle leaving thin beveled edges firmer union and better scar are attained by first cutting away the "bevel" on each surface to convert the edges into vertical ones, due to the fact that these bevel edges have little blood supply left. The procedure in such cases will depend upon the location and extent of the wound, and if this trimming is not found to be practical then the sutures should be placed farther away from the skin edges than is customary and tied loosely to prevent crawling, and a snug bandage applied. For small wounds of this type narrow adhesive strips are often preferred to suture. In the incised wounds diagnosis must be complete, for it is this type of wound that occurs so frequently about the hand and wrist due to windshield glass, shoemaker tools, oyster knives, etc., and is so often associated with damaged tendons.

Repair of lacerated wounds entails good preparation of the wound and adjacent tissues, removal of all loose particles by mechanical means and debridement of devitalized tissues, especially in scalp wounds. Unless this is carefully done infective organisms are almost certain to invade the tissues. Where a wide dissection of devitalized tissue is necessary, undermining the skin on each side will aid in effecting a closure but should be avoided unless not to do so would produce undue strain on the skin sutures. For the small wounds of this type it is often possible to excise it completely. Antitetanic serum is indicated.

Gun-shot wounds are occasionally seen in emergency room practice as minor injuries. Bullets near the surface, in a joint, or in or near a vital organ should be removed. Infected bullet wounds are to be laid open for drainage, but the greater number need no probing and only routine treatment of the local wound, with special attention to treatment of shock and the prevention of tetanus and gas-gangrene. The important step in the minor wounds is the administration of combined antitoxin and the necessity for its being repeated when later an attempt is made to remove bullets or to repair ununited bone, though it may be months after the original injury.

First degree burns respond to unguentine, butesin-picrate or tannic-acid ointment in the early stage of treatment. When the blisters burst and the skin can be removed zinc-oxide is an excellent dressing. The Journal of the American Medical Association for June, 1917, described a paraffin ointment that is an excellent impervious dressing for first degree burns.

After establishment of drainage the small infected wound will respond readily to daily cleansing, removal of slough with sterile forceps, application of non-irritating antiseptic and a dressing of boric-acid ointment. The more extensive and spreading infections which demand more active treatment in the form of drains, etc., are not considered here because of lack of time.

One troublesome problem of a minor nature that is very commonly seen is the indolent or trophic ulcer following infected abrasions or scratches or direct blows over a superficial bone such as the tibia. These hard, crater-like ulcers have a stubbornly chronic tendency and respond very poorly to treatment by astringents and ointments. A little zinc-oxide ointment covered by a thick gauze pad and strapped down forcibly directly over

the sore with an elastic adhesive will remove the rubber-like ulcer bed and promote healing more quickly than usual treatment with ointments alone.

The most common sprain is that of the ankle, the result of sudden inversion of the foot. This causes stretching or tearing of the various ligaments, most commonly the lateral. On the whole this lesion is poorly treated due in part to the fact that so many times it receives only "home" treatments in the form of hot soaks and partly because of the lack of appreciation of the actual pathology. Severe sprains are best treated by complete fixation as soon as possible. When delay is unavoidable the foot and leg should be elevated, with the patient at rest in bed, and ice-bags or cold wet compresses applied. If the case is seen before swelling has appeared, or is only slight, immediate strapping of the ankle with the foot in neutral position is proper. Two or two and one-half inch lateral strips are applied on both sides of leg to prevent inversion and eversion, and are reinforced by circular straps arranged solidly from the metatarsal arch to about four inches above the ankle leaving out the heel and lower part of the tendoachillis. This will minimize swelling, and if much swelling is anticipated, it may be augmented by a cloth bandage over the adhesive from the toes to the knee; the cloth bandage may be removed the next day. Thorough strapping will immobilize the ankle completely except for slight flexion and extension and the patient can be allowed up on his feet. In cases of an excessive amount of early swelling or enough skin damage to prevent strapping, immobilization should be secured by immediately applying a plaster of paris cast.

Sprains at the wrist are less frequent and usually less severe than at the ankle; however, the same principle applies to both locations, namely, adequate fixation for sufficient length of time to allow the damaged ligaments to heal. The most troublesome complication of sprains at the wrist is tenosynovitis which results from indaquate fixation for too short a period of time. The value of x-ray examination of all severe sprains cannot be overemphasized. Many of these injuries are in reality a sprain-fracture, or at the wrist prove to be a carpal fracture, neither of which can be diagnosed properly without the aid of x-rays.

Those fractures usually treated in the office are fingers and toes, Colles' fracture, and fractures of the metacarpal bones. Nowadays most fractures of the clavicle are seen first at the hospital where the patient has been sent as an emergency for x-ray before the doctor is called. Such cases are all easily handled under local anesthesia by the individual surgeon's choice of methods. Longitudinal or incomplete fractures of the phalanges or metacarpals are often associated with lacerated or contused wounds about the hands and may be easily overlooked if the importance of x-ray in all suspicious cases is not realized. Lack of time does not permit detailed discussion of these injuries.

CONCLUSIONS, AND SUMMARY

1. The growing importance of minor surgery is stressed.
2. Attention is called to careless methods of handling simple injuries and their resultant complications.
3. Minor accidents come in at unusual hours, day or night, but proper treatment is immediate treatment and time must not be spared.
4. Proper treatment of mild injuries will lessen complications and thereby prevent disability, minimize disability and return the patient to regular duties in the shortest possible time; an important economic consideration in industrial cases.
5. Suggestions for treatment of some of the injuries most commonly seen are offered.

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DISCUSSION

Dr. Walter C. Jones, Jr., Miami:

I first would like to state that I think Doctor Netto has very carefully and conservatively covered this subject in the time allotted to him. I feel that the physician in industrial surgery plays a dual role. He not only acts as the protector of a patient's welfare but as well, he must consider the welfare of the industry. No man should attempt to do industrial surgery unless he is willing to assume the responsibility of those patients on the same basis as that of his own private individual cases.

Nothing plays a greater part in the protection of both parties than early reports. These things may be of little consequence materially as far as the individual is concerned but later may entail considerable expense on the part of the company and considerable disability on the part of the patient himself. A simple lesion or wound of a finger can be most embarrassing to the physician in charge of the case later.

Tetanus faces us all and carries with it a certain amount of danger, especially if we fail to carry out the proper prophylaxis. We all recognize this in the severe lesions associated with extensive contusion where it is not possible to completely eradicate the source of infection. I feel we should be on guard for tetanus developing even though there has been an original dosage of antitoxin and possibly, we should repeat the dose of antitoxin. The prolongation of prophylaxis from the serum is rather limited in the second and third dosage, much more so than it is in the first.

I cannot emphasize too strongly the need for debridement in handling industrial cases. This should be most radically done; all devitalized tissues should be removed. All foreign bodies and foreign materials in and about an incised wound must be removed if it is humanly possible. We have no ideal antisepsis. We must get rid of that possible bed for infection and that is best handled by means of debridement and thorough cleansing rather than depending on antisepsis. Nothing is of greater importance than is fixation. In torn lesions, it is a very important thing and a considerable disability can be prevented by proper care at the time of the individual wound.

Christopher has a very excellent little procedure in the laceration of the tendon of the forearm in which he places a tourniquet very tightly forcing the tendon down into the lacerated wound. I have found it to be of considerable value in all of these tendon cases.

I think this is a subject that is facing us more and more as medical men especially those of us who are interested in industrial surgery. We must handle these cases with the same responsibility as with the most wealthy patient. Until we can, I think it is unjust that we should attempt to handle industrial cases.

Dr. Joseph S. Stewart, Miami:

I am delighted that Doctor Netto has chosen to discuss this subject. I think it is a very important subject and important because we are so likely to belittle it.

The first thing I would like to discuss is the punctured wound. We have a tendency to belittle it. It is one of the most frequent things we handle both in our private practice and in industrial accidents. Our routine is to use the smallest gauge hypodermic needle, about one inch in length, take 1% novocaine, and by inserting the needle at the site one time the area can be completely anesthetized. Our custom is to make an excision of the wound and follow down as far as contused tissue can be seen. I agree strongly with the first discussor in regard to antiseptics after excising the area. We do nothing else but apply a small sterile sponge to it. Very rarely does such a debridement cause any disability whatever.

One other thing that has not been mentioned: I recently saw a case with Drs. Walter Jones and Tom Otto. I gave an estimate of the disability in the finger as between 90 and 95%; Doctor Jones gave an estimate of 80%; Doctor Otto gave an estimate of 25% and the insurance man wanted to know what he could do if we differed so on the percentage of disability. None of us had any particularly accurate way in which to arrive at the percentage of disability. Since reading McBride's new book on this, I don't believe we will be so far off again on arriving at the disability. I commend the book to you. It teaches us to be a little more accurate and a little more scientific in arriving at an estimate of disability.

Dr. Eugene L. Jewett, Orlando:

Doctor Netto's very interesting and instructive paper impresses on us once more the proximity of traumatic surgery in practically everyone's medical and surgical practice. A very important branch of this specialty is the diseases which are encountered in many industries. A traumatic surgeon has to be on speaking terms with a large number of conditions arising from the use of various poisonous products. I shall not go into the details of such dangerous products and the prophylaxis and treatment of their sequelae.

Another point I should like to emphasize is what Dr. John J. Moorehead, the Father of Traumatic Surgery, has said so often, namely, the importance of attending to wounds within the golden six-hour period. After six hours it is generally better to debride and close the wound with delayed suture. By this latter is meant to place the sutures but do not close the wound until twenty-four hours have elapsed without any signs of infection. The muscle should be cut back until it has normal color, normal contractility, and it bleds. In cases of contaminated wounds we generally thoroughly cleanse the skin around the lesion with benzene followed by green soap and water. The lesion itself is kept covered and care is taken not to carry infected material from the adjacent skin margins into the wounds. Then Doctor Moorehead's practice of irrigating the wound with a large quantity of iodine-saline solution is excellent. This solution contains one dram of iodine to a pint of normal saline, and is run into the wound through a fine nozzle or tube to the depth of the lesion. This mechanical washing away of foreign matter is of the utmost importance. Personally, I never use iodine or any strong antiseptic in an open wound, but many men do use the tincture or the three and one-half per cent iodine. Böhler's practice of exposing the repaired wounds to the air and sunlight at once with no dressing of any kind is in many instances most commendable. I have seen hundreds of his patients in the out-patient clinic and wards in his hospital in Vienna with very few serious infections or massive sloughs.

Speaking of anesthesia, I must mention the revolutionary products, novocaine, avertin, and evipal. With these "big three" we are able to adequately treat most of the acute traumata met in traumatic practice. Of course, avertin has its place in a hospital, but novocaine and evipal fill a great place in the office supply list. Practically all of the fractures that can be treated in an office or a clinic can be taken care of very satisfactorily with the use of novocaine anesthesia. I must caution, however, against trying to use novocaine after twelve hours post-trauma. Its efficacy depends on its permeating throughout all the ramifications of the fracture site, and a solid blood-clot does not allow for this uniform dissemination.

I want to commend Doctor Netto especially for his insistence on a thorough training in this most important field. There are several traumatic courses given in this country, and it is well worth while for doctors doing any of this work at all to keep abreast of the latest advances whenever possible. The welfare of the patient must be always kept uppermost in mind, and the functional result should be the one most assiduously sought after. Doctor Moorehead's rating of function 60, union 20, and contour 20 is an excellent way to judge the final result of a fracture. The Massachusetts General Hospital of Boston, Mass., uses the 4 (normal anatomic) 4 (normal symptomatic) 4 (normal economic) which is likewise a very good classification.

In closing let me implore everyone to get a thorough follow-up on the traumatic case, so as to get a correct final rating and thus learn and improve.

Dr. Lloyd J. Netto, West Palm Beach (Concluding):

I should like to thank first of all those who took part in the discussion for their generous attitude. I do feel that it is a very important subject not properly stressed in our meetings. The paper was written with regard to minor injuries of all kinds. Naturally, the industrial work enters into it for that is the source of most of these cases. However, it was not written entirely from the standpoint of industrial work; it is important in cases from all sources.

As for the matter of records that has been discussed already, I intended to mention it in the paper. Time was not sufficient to mention the importance of keeping records of both the private and compensation patients. In private cases, it is most desirable to have records. Most automobile accident records come into court. In industrial cases, it is imperative. In one case we had an old man who fell from a scaffold and had a fracture. He was treated by accepted methods but had about one-half inch of shortening, when the leg healed. I mentioned something about this and he said, "Don't worry; I have had three-fourths of an inch all my life." Such a record is invaluable.

In a good many cases of the extensive

lacerated wounds, contusions, etc., you need only to leave the site open, allowing them to heal by second intention. Most of the discussors have brought out the fact that proper cleansing and debridement eliminate the necessity for the use of antiseptics. Under those circumstances, antiseptics are not necessary.

General anesthesia was not mentioned. I wanted to mention ethyl chloride spray only to condemn it. I do not use evipal in office practice very often because of the fact that occasionally you will find a patient who will sleep several hours instead of the customary forty-five minutes. I do use it in the emergency room services or for short operations in the hospital.

I believe that the discussors (and it pleases me greatly) do feel the need of emphasizing the importance in all of these simple appearing things for immediate and sufficient treatment at the beginning. Every doctor has his own method for treating these cases and so long as sound principles prevail the individual technique is not important. Whether they be industrial, accidents on the highway, or whatnot, they should be given careful study and preparation the same as for any other sort of operation.

URINARY INFESTATIONS WITH TRICHOMONAS VAGINALIS IN THE MALE*

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The parasite Trichomonas vaginalis was first described by Donne in 1836, and since that time there have been so many reports of its occurrence in women that now the entity of Trichomonas vaginalis infestations is known to every physician. Miura, in 1893, was the first to note the presence of this organism in the male, which he found in the freshly voided urine of a fifty year old man who had no urinary symptoms. The following year Marchand reported a case of Trichomonas in a male sixty years of age, who had had a perineal fistula for seventeen years. Since then, occasional reports have found their way into the literature. An interesting case of Trichomonas infestation was reported by Katsunuma in 1924, in which the parasite was found in the urine of a three year old boy. Further study of this case showed the source of the parasite to be the preputial sac, where it had caused a balanoposthitis. Riba and Perry, in 1929, added two further cases to the literature.

Capek, in 1927, and Grimm, in 1930, described cases of Trichomonas urethritis in the male. In discussing Trichomonas prostatitis, May, in 1932, showed by cystoscopic examinations that the bladder is not necessarily involved in these cases. Involvement of the renal pelvis by the Trichomonas vaginalis organism was reported by Lewis and Carroll, and later by Ayer and Neil. In 1931, Rosenthal reported the case of a male, aged seventy-two, who developed symptoms of urinary infection five weeks after a gall bladder operation. Trichomonas vaginalis organisms were found in the urine, and renal casts containing a flagellate form were seen. However, Rosenthal felt that the symptoms in this case were due to the presence of Bacillus coli.

A suitable culture media has been developed by Packanian which consists of egg yolk, charcoal, starch and blood serum. Trichomonas has been grown in this media for a period of four to six days in the incubator. The organism is quite sensitive to external conditions, and is readily killed by drying. Cysts or other resistant forms have not been shown to exist. If the organism is incubated as collected, i. e., in the prostatic fluid, it is viable for only six to eight hours. Very mild antiseptics kill the organism readily in vitro. Riba successfully cultured the organism in equal parts of ascitic fluid and Ringer's solution. The culture had to be reinoculated every five days.

It is important that the secretion obtained by stripping the urethra or massaging the prostate be examined in the fresh unstained state, as it is difficult to identify this protozoan in the ordinary stained smear. However, if stains are used, the Gram stain with basic fuchsin as the counter stain is one of the best. A small amount of saline solution may be added to the secretion and a hanging drop preparation made to facilitate the examination of unstained specimens. On cold days this saline solution should be warmed before using.

The Trichomonas vaginalis belongs to the

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flagellate infusoria. It is a pear-shaped organism averaging 15 to 26 mm. in length and 7 to 16 mm. in width. Its outline is sharp and its cytoplasm finely granular. The nucleus is seen in only the stained specimens and is about one-third the length of the organism itself. The flagella are attached to the anterior end of the organism and vary in number from one to four. Some specimens show a short tail at the posterior extremity, and others an undulating membrane attached to the side. Two other types of Trichomonas which closely resemble Trichomonas vaginalis are found in the human body. These are T. buccalis and T. hominis. The first is said to be found in the mouths of about fifty per cent of the population, while the second is found in the stools of about ten per cent of normal individuals.

Accurate statistics are not available to show the frequency of Trichomonas infestations in the male. Opinions expressed in the literature show great variation. For example, 32,000 prostatic examinations in the Mayo clinic showed the presence of Trichomonas vaginalis only sixteen times. However, Nitschke demonstrated the presence of the organism five times in forty cases of so-called nonspecific urethritis. Pelouse reported eight cases of prostatic infestation during a period of four years. Allen discovered six instances of prostatic involvement by examining the husbands of patients known to harbor the Trichomonas. Drummond reports a similar series in which he found four cases of prostatic infestation with the Trichomonas organism during the examination of five men whose wives were infected with this organism.

As a general rule, the only complaint that the patient has is that of a slight watery discharge from the urethra. Even this may be entirely absent or so slight as to be noticed only by the most fastidious. Other urinary symptoms are usually absent. It is not believed that this organism is a pus former, per se, as other bacteria, usually the streptococcus, are present also. There is much controversy as to whether Trichomonas vaginalis is really pathogenic or only a secondary invader. A number of workers believe that the lesion is produced as the result of the symbiotic union of the Trichomonas with secondary organism, of which the streptococcus is the most common. Cases of vaginitis, identical in type with the typical vaginitis caused by the Trichomonas are described, in which it was impossible to find the protozoan.

The most important phase of the treatment of Trichomonas infestation in the male is the prevention of reinfection by the female. It is evident that the male may carry the organism in his prostate and repeatedly reinfect his wife, and in turn be repeatedly reinfected by her, regardless of the treatment she might be receiving at the time. For this reason it is most important that the husband be examined and treated along with his wife whenever she is found to be infected; for only in this way can either of them be ultimately cured.

The observations of Allen and Drummond are ample evidence that the male may be completely unaware of his infectiousness, and thus be overlooked by the physician in his efforts to eradicate the infection in the wife. Therefore, in combating this infection, it is quite evident that both sex partners must be under treatment at the same time in order to prevent an endless process of reinfection.

The marked contrast between Trichomonas vaginalis infections and infections with the gonococcus is well brought out by Nitschke, who calls attention to the fact that in gonorrheal infection the female is infected by an infected male, and she in turn infects other males. However, with the Trichomonas we are dealing with a different situation, in which the exact mode of infection is not known. The incidence of Trichomonas infestations is relatively high in both married and unmarried women and does not depend to any great extent on sex relations for the primary infection.

A large number of cases in the female undoubtedly occur as result of autoinoculation, because of the close proximity of the rectum and vagina. Fewer cases are seen in the male because of the absence of any autoinoculation process, together with the fact that the infection is superficial and the urethra is frequently cleansed by the urinary stream. It is the general impression among most observers that the male acquires the infection only through sexual contact.

Until there has been a proper evaluation of the great number of advocated techniques in a large series of patients, the treatment of Trichomonas infestations in the male will continue to be a matter of personal experience and

preference. A great many antiseptics have been used in the treatment of this infection, among them being mercuric oxicyanide 1:4000-1:2000, acriflavine 1:3000, and metaphen 1:8000. Pelouse uses prostatic diathermy followed by the instillation of 1:3000 acriflavine solution into the bladder with a bulb syringe. Some of this solution is allowed to remain in the urethra for ten minutes. These treatments are given on alternate days. Usually six consecutive treatments are given, though most cases are cleared up after the first three or four. Drummond uses through and through irrigations of the urethra with 1:8000 metaphen, and then injects three cc. of electargol into the lateral lobes of the prostate through a McCarthy panendoscope. He found that one such treatment was usually sufficient.

Riba has obtained excellent results in his cases with posterior instillations of 0.25 per cent solution of silver nitrate, and three anterior instillations with five cc. of the same strength. The author favors the use of the Elliott treatment given on alternate days, together with daily instillations of 1:3000 solution of acriflavine into both the bladder and the urethra, and retained for ten minutes. Excellent results may also be obtained by through and through bladder irrigations, using a quart of one-half to one per cent phosphoric acid solution. The acid may be used on alternate days with the acriflavine solution, if so desired.

CONCLUSIONS

Trichomonas vaginalis infestations in the male occur with sufficient frequency to warrant its being looked for as a routine in every case of so-called nonspecific urethritis, and in every case in which the mate is known to be infected with the organism regardless of the absence of symptoms. The male undoubtedly harbors the organism in his prostate, and may repeatedly reinfect the female through intercourse. Trichomonas vaginalis infections have often been confused with other nonspecific discharges of the male urethra, when the physician fails to examine the fresh unstained specimen for the organism. Most treatments are satisfactory if the sex partner is treated at the same time. The author favors the Elliott treatment used together with instillations of acriflavine, or irrigations with phosphoric acid.

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THE ELLIOTT TREATMENT IN THIRTY-THREE CASES*

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Sebring

A considerable literature has accumulated since the early articles on this subject appeared in 1931, and a great deal has been learned as to what cases are best suited to this treatment. When a physician first obtains a new apparatus, there is always the tendency to try it in many types of cases. Some of these cases will be found to be ill-suited to the treatment, and the results disappointing. Sufficient data have been accumulated so that it is now possible to know in advance what results may be obtained through the use of Elliott treatments.

Dr. Charles Robert Elliott has devised an instrument consisting of various parts: an electric motor, tank for distilled water, ther-

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mostat, pressure regulator, inflow and outflow rubber tubes, valves, gum rubber distensible bag. There is excellent heat control, so that even temperature of the water running through the distensible bag may be maintained at any desired level. There is a lever which controls the amount of pressure within the distensible bag. Treatment is usually begun with the temperature 115° to 118° F. and the heat increased one-half to three-quarters of a degree a minute, up to 130° F., which temperature is maintained for one hour.

The first treatment lasts one-half hour, the second three-quarters of an hour and the temperature is usually not raised above 125° for the first two treatments.

The patient lies supine with a folded blanket or pillow beneath the knees. It is well to have the pelvis slightly elevated. The perineum must be carefully protected to avoid a burn, the rectum and bladder empty. In order to determine the proper pressure inside the rubber bag, it is well to introduce a finger alongside the bag at the time of the first treatment. There is some danger of getting a burn if too little pressure is maintained in the bag. After each treatment, there should be a careful examination in order to detect even a slight burn and to thoroughly remove all mucus and exudate which flow freely from the cervix. In case a burn should occur, the treatments are continued but the temperature of the water is not allowed to be as high as before. There is some difference of opinion as to whether treatments should be discontinued during menstruation. I have not discovered any bad results from employing them during menstruation.

What results are to be expected from such a procedure? The temperature in the vagina, rectum, in the bladder, in the cervix and in the pelvis is considerably raised—from 104° in the bladder to 106° in the anterior rectal wall and 130° in the vagina. The general body temperature is raised not more than four-tenths of a degree. There is a leukocytic increase of 17.1 per cent in 87 per cent of the cases. The increased heat causes a correspondingly increased circulation with increase in phagocytosis. Inflammatory exudates are more rapidly absorbed; a mucus discharge flows freely from the cervix whose glands are shortened and flattened by the pressure of the distensible rubber bag. Bacteria are caused to be washed out by the increase in secretion and are actually destroyed by the heat. The patient often sleeps during the treatment and experiences a relief from pain and a feeling of well-being after the treatment.

From June 30, 1934, to August 1, 1936, I administered to 33 patients a total of 331 Elliott treatments, or an average of 10 treatments a case. Three patients had only one treatment each and will not be included in the following figures. Of the remaining 30 cases, 24, or 80 per cent, gave good results; 3, or 10 per cent, gave fair results; while 3, or 10 per cent gave poor results. Satisfactory results were obtained in 90 per cent of the cases.

In analyzing the three cases in which poor results were obtained, it was found that the first patient had had a pelvic inflammation of gonococcic origin for which she had undergone an operation, but still suffered pelvic pain. This patient probably has disabling adhesions but might still be benefited by sufficient treatment. I did not feel that she had given the treatment a thorough trial when she chose to discontinue it. The second failure was in a young woman who suffered greatly during her menstrual periods. I feel that sex repression played an important role in this case. The third case was of the type in which, ordinarily, excellent results can be expected, and I have no satisfactory explanation for failure of the treatment. It was a case of pelvic inflammatory disease and the patient was given fifteen treatments.

The best results were obtained in treating acute gonococcal pelvic inflammatory disease —the so-called "frozen pelvis," gonorrheal prostatitis, leukorrhea of gonococcal or non-gonococcal origin, painful menstruation, pelvic inflammation following abortion and pelvic inflammation both before and subsequent to operation in old gonorrheal cases. Counsellor of the Mayo Clinic reported in 1933, 87 per cent good results and stated that more careful selection of cases would have given a much higher percentage.

I feel that we have in the Elliott treatment a useful adjunct to medical treatment.

OCULAR COMPLICATIONS FOLLOWING DENGUE EPIDEMIC OF 1934

Marshall Faver, M.D.,
Miami.

I was very much interested in the dengue epidemic which raged in the southern part of Florida during the summer of 1934 and wish to report the ocular complications following this epidemic, not with the thought of contributing anything original, but rather as another brief record of this strange malady.

There were over 15,000 cases of dengue fever in the Greater Miami area. The epidemic commenced the latter part of June and reached the height of intensity August 16, gradually decreasing until December.

Dengue is an acute, epidemic, eruptive fever occurring chiefly in tropical and subtropical localities. The onset of the disease is sudden, with high fever, chill, severe pains in the frontal and orbital regions and in the joints, bones and muscles. There are two febrile paroxysms with an intermission. The primary stage lasts about three days and is followed by an abatement of symptoms for a period of two, three or four days, when the second paroxysm is ushered in. Many authors believe dengue may readily be confounded with influenza. Hargrave[3] says: "During the first week of this epidemic the opinion was that we were dealing with influenza. Practically all of the cases the first week were reported among the natives. As soon as the disease appeared among the white element and a more detailed study was made, where the rash, leukopenia and other characteristic manifestations were observed, a diagnosis of dengue was established."

No evidence has been adduced to support the fact that dengue is contagious. The report of Ashburn and Craig,[2] who conducted extensive researches and clinical investigations in the Philippine Islands in 1907, shows that dengue is transmitted from man to man through the bites of mosquitoes. Siler, Hall and Hitchens[10] say: "The mechanism of transmission briefly is as follows: the dengue patient infects mosquitoes during the first three days of illness; the infected mosquito is able to transmit the virus eleven days after its infection; infected mosquitoes remain infective throughout life; hereditary transmission of the virus does not occur."

The mosquito, *Aedes aegypti,* breeds in backyard litter, such as empty cans or any receptacle that contains water long enough for the eggs to develop. The control of epidemics of dengue is accomplished by the reduction in the mosquito population of the community.

There are a great many beliefs as to the immunity of dengue. Some believe immunity is acquired with the first attack. Hare was able to prove in Australia that the immunity conferred by an attack of dengue does not go beyond the first year. Maurice Bargy[4] reports a case, treated by Degorce, of dengue fever recurring three times in five years with recurring ocular complications.

Dengue fever strikes the visual organ from the beginning; certain ocular symptoms appear before any other definite diagnostic signs of the disease. The ordinary symptoms are usually retrobulbar pain, conjuctiva injected, photophobia and sometimes lacrimation. At the onset, and usually lasting all through the attack of dengue, the retrobulbar pain is so severe as to become almost unbearable. The pain is intensified by movement and there seems to be a peculiar stiffness in the muscles of the eyes. Gill[6] says: "It is not unlikely that the retrobulbar pain soreness is due to a myositis or myalgia of the extrinsic muscles of the globe similar to that which occurs in influenzal infections. When one recalls that other muscles in the body are affected with pain and soreness in dengue fever, it does not seem unreasonable to assume that a similar condition may affect the extrinsic muscles of the globe. This high percentage of occurrence places postorbital pain in an important place, so far as its diagnostic value in dengue is concerned." In many young children, during mild attacks of dengue, I have noticed that the only pain complained of was pain in back of the eyes and a feeling of sand under the lids.

Photophobia was present in almost every patient. Photophobia was so severe and so painful that many times patients remained in dark rooms, or wore dark glasses if it were necessary to be in a lighted room. Quite frequently lacrimation was complained of; the irritation of the retina caused by strong light is sufficient to cause an increase in the tear secretion.

All attempts to find a causative organism in dengue has been quite futile; dengue virus fails to penetrate the human skin and is not spread by contact. Ashburn and Craig have proved that the unidentified causative agent is present in the blood stream, by producing dengue fever in non-immune volunteers through the injection of blood from patients with the disease. While treating my patients, direct smears were made from the conjunctiva and examined for microorganisms. All smears and cultures were found to be negative. From these observations, the conclusion was reached that the toxin circulating in the blood of the dengue patient was the chief cause of the conjunctival injection and discharge as well as the reason for the complicated ocular disturbances.

Although I have made an extensive search, I have not found mention of glaucoma complicating dengue fever in this country. M. Trantas,[18] in a report of the dengue epidemic in Athens in 1928, says he has noticed many cases of glaucoma during the course of this disease. Bistis, also reporting the epidemic in Athens, states he has observed glaucoma as a complication of dengue. Anargyros[1] reported five cases of ocular complications observed during the same epidemic, two of which were glaucoma. The first case appeared on the fourth day of the fever, in the left eye and two days later there was an attack of glaucoma in the right eye. Iridectomy was performed on both eyes. The second case was a patient aged fifty-four years who had lost the sight of his right eye from glaucoma, two years previously. After the fever subsided the right eye became infected and so severely painful that the eye had to be enucleated, and it was found to be full of blood clots.

I wish to report the following case of glaucoma: Case 1, On Sept. 28, 1934, E. R., carpenter, age 65, was seen at the City Clinic, complaining of unbearable pain in his left eye. A diagnosis of dengue had been definitely established nine days previously. The patient stated that on the second night of the fever, his left eye became inflamed and severely painful. The family history was definitely negative.

Examination: Pupil of left eye was dilated 6 mm. Vessels or optic nerve of left eye were not visible with ophthalmoscope. Tension with Schiötz's tonometer was: right eye 18, left eye 85. Vision: right eye 6/60; left eye, counted fingers at six inches.

Treatment: Elliot's corneal scleral trephine and peripheral iridectomy was performed the following day, Sept. 29. On October 8, the pupil was 4 mm., optic nerve well seen, vitreous cloudy, vision gradually improving. Oct. 24, tension was O. D. 18, O. S. 25. Ten drops of potassium iodide were given orally, three times a day. The patient did not return again until Dec. 7, 1934, at which time he stated there had been no attack of pain or poor vision since the operation. Tension at this time was 18 in both eyes and vision had improved to 6/20.

I feel it would be well, also, to report the following cases: Case 2. On August 22, 1934, R. R. G. mechanic, age 33, came into my office complaining of severe pain in both eyes. His family physician confirmed a case of dengue fever, one week previous to his visit to my office. The patient stated that the fever lasted three days and as soon as the fever left, both eyes became inflamed and very painful and his vision was gradually growing dim. I was unable to learn anything of importance in his family history.

Examination: The pupils of both eyes were dilated 6 mm. and fixed, posterior synechia, subconjunctival hemorrhage, cornea slightly hazy. Vision: O. D. 6/12 J 4; O. S., 6/20 J 3. Pigment of iris had faded, apparently atrophied. Ophthalmoscopic: vitreous slightly cloudy both eyes, optic disc and vessels normal.

Treatment: Eyes gradually improved under treatment of atropine and hot compresses. On Sept. 5, vision had improved to 6/7.5 in both eyes. I discontinued the use of atropine and used dionin several weeks with good results. On October 12, vision was O. D., 6/6 J 1; O. S., 6/7.5 J 1. Eye grounds normal. Patient discharged.

Case 3. M. T. H., waiter, age 31, was first seen on Sept. 6, 1934. He complained of his left eye which was inflamed and watering and of an irritated feeling as if sand were in the eye. A diagnosis of dengue had been confirmed eleven days previously. He stated that his left eye became inflamed and irritated two days before the onset of the fever.

Family history negative.

On examination of left eye, I found upper and lower lids inflamed with tiny nodules, conjunctiva injected, pupils 2 mm. both eyes, cornea clear. Laboratory findings negative.

Treatment: zinc sulphate and hot compresses were used for several days with no improvement. The lids were treated with ½% silver nitrate in the office, daily. There seemed to be a slight improvement one day and the next day the eye would appear worse. Treatment was continued for thirty days. The patient was discharged on October 8 when vision was 6/6 J 1 in both eyes.

Case 4. C. E., student, age 17, was first seen on Sept. 24, 1934. He complained of his right eye being inflamed, tearing and painful for one week. Eleven days previously he developed symptoms of dengue fever. Five days after onset of fever, the right eye became inflamed and painful.

Examination: Tiny vesicles giving the appearance of dendritic ulcer when ruptured, extending across cornea from limbus to limbus; pupil 6 mm.; conjunctiva injected. Ophthalmoscopic—eye grounds normal.

Treatment: Tincture of iodine was applied to ulcer daily for several days with no noticeable improvement. New vesicles would appear from time to time. Quinine sulphate was given internally, twenty grains a day over a period of two weeks. Hot compresses were used four times daily for thirty minutes each time. On October 8, a therapeutic copper ball was used on the ulcer. There was a slight improvement after three days, then the eye began to tear again, grew painful and seemed to be worse. The patient was given 50,000,000 typhoid vaccine (Lederle) intravenously. There was a good reaction, temperature 103 and the eye began to show improvement immediately after vaccine was given. Recovery was uneventful and patient discharged Nov. 12, after eight weeks of intensive treatment.

CONCLUSION

1. Three cases of herpes of the cornea were seen. All showed only a slight sensitiveness, were very slow healing and no causative agent was found in the smears. Even the serum from the vesicles was negative.

2. The toxin circulating in the blood of the dengue patient, as well as the effect of the toxin on the fifth cranial nerve, has a great deal to do with the slow progress we make in treating corneal complications.

3. Smears and cultures were made from all ocular complications during this epidemic; all were found to be negative. This will confirm the reports of other ophthalmologists during previous epidemics.

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INSURANCE RESOLUTION

Representatives of two insurance companies selling hospital insurance in Florida requested guidance from the officers of the Florida Medical Association. The officers of these insurance companies desired to have their policies so worded as to conform with the wishes of the doctors in Florida. An editorial in this connection appeared in the October, 1937, Journal. After careful deliberation, with the cooperation of the A. M. A., the following resolution was adopted by the Executive Committee of the Association:

RESOLUTION ON HOSPITAL AND HEALTH INSURANCE

Whereas experience throughout the centuries has established between the patient and his physician a relationship of individual freedom and individual initiative, and

Whereas such a relationship has resulted in greater benefit to the public than any other method of distributing medical care to the sick, and

Whereas the available evidence is that no proposal of a plan superior to this has been offered, be it

Resolved that the Florida Medical Association looks with unequivocal disfavor upon the control, direction, or employment of doctors of medicine by any lay individual, group, association, or corporation, whereby the services of such doctors are to be sold or dispensed by the said individuals or agencies, and be it further

Resolved that the Florida Medical Association does not look with disfavor upon health and accident policies sold by legally qualified insurance companies, whereby the benefits of such policies are payable in cash to the insured.

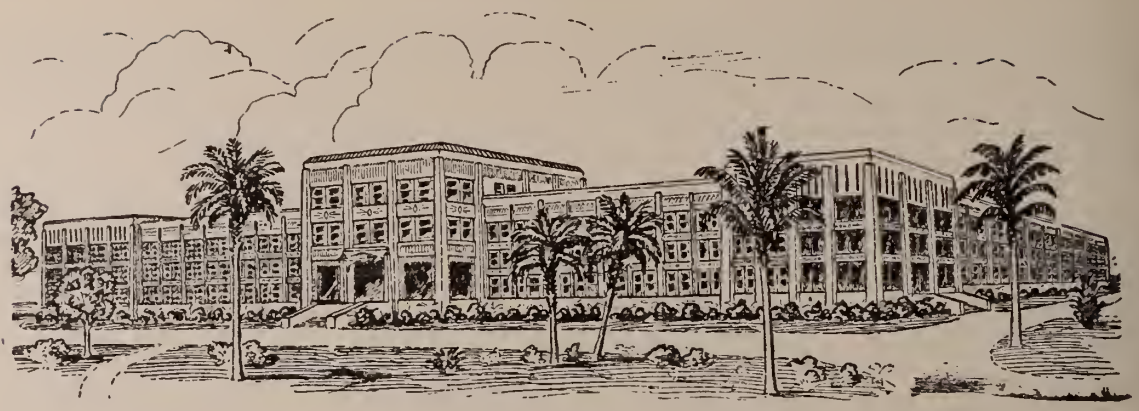
FLORIDA'S TUBERCULOSIS SANATORIUM

Florida's first State Tuberculosis Sanatorium near Orlando was dedicated and officially opened January 3, 1938. Dr. J. Arthur Myers, Minneapolis, president of the National Tuberculosis Association and international authority on tuberculosis was the principal speaker at the ceremony.

The Sanatorium is a three-story brick and concrete structure, modernistic in design and located on one of the highest points adjacent to Orlando. It faces southeast and overlooks a small lake. The building is situated in the center of a 160-acre tract of land donated by the City of Orlando.

The opening of the Sanatorium brings to a close ten years of effort on the part of the Florida Medical Association, Florida Tuberculosis and Health Association and other organizations, to provide hospitalization for the tuberculous of this state. The Sanatorium with equipment, powerhouse, sewerage disposal plant, laundry and nurses' cottages, will cost approximately $700,000. It was financed through a state appropriation and a loan-grant from the Federal Emergency Administration of Public Works. The Orange County Board of Commissioners and the Florida Works Progress Administration are cooperating on a project for beautification of the grounds. Roads built by the county surround the building and connect the property with the nearby main highways.

The interior of the building has single rooms and two, four and six-bed wards. It is equipped to accommodate 312 patients although the building will house more than 400 patients when the State Tuberculosis Board has funds to purchase additional equipment.



STATE TUBERCULOSIS SANATORIUM

Equipment is the most modern, up-to-date and scientific available. Two operating rooms are located on the third floor. A well equipped laboratory and x-ray department are also located on the third floor adjacent to the operating rooms. Treatment rooms are located on each floor to expedite examinations and pneumothorax and other treatments.

One wing of the building is for Negroes and will accommodate approximately 125 patients. Facilities for Negroes duplicate those for whites. Rooms for treatments, dentistry, eye, ear, nose and throat work, recreation, dining rooms for ambulatory patients, and screened porches are provided in the Negro wing, connected with the main building by an arcade. Negro nurses live in a penthouse above the Negro wing.

Dr. R. D. Thompson, formerly medical director and superintendent of the Wisconsin State Tuberculosis Sanatorium, is medical director and superintendent of the institution. He was selected by the State Tuberculosis Board upon recommendation of the Tuberculosis and Public Health Committee, Florida Medical Association. This Committee has acted as technical advisor to the Board throughout the life of the project. Doctor Thompson has specialized in tuberculosis and sanatorium work for more than twenty years. His medical assistants are Dr. L. H. Kingsbury, chief resident physician; Dr. Harold H. Brueckner, senior resident physician; Dr. William O. Fowler, junior physician and Dr. H. H. Green, Negro resident physician.

More than 2,000 persons inspected the building on the opening day. Luncheon was served through the courtesy of the Greater Orlando and Orange County Chambers of Commerce. The dedicatory program was as follows:

Presentation to Florida by Federal Emergency Administration of Public Works—F. A. Buck, Atlanta, Federal Emergency Administration of Public Works.

Acceptance by Florida—M. O. Overstreet, Orlando, personal representative of Governor Fred P. Cone.

Appreciation Florida Medical Association —Dr. Edward Jelks, Jacksonville, Pres., Florida Medical Association.

Appreciation of Negro Group—Dr. Wilmoth H. Baker, Tallahassee, Chairman, State Negro Tuberculosis Committee.

Dedication—Dr. E. C. Gillette, Jacksonville.

Address—Senator C. O. Andrews, Orlando.

Address—Dr. J. Arthur Myers, Minneapolis., Pres., National Tuberculosis Assn.

Many prominent persons were introduced by W. T. Edwards, Jacksonville, chairman of the State Tuberculosis Board, who presided at the ceremonies. Telegrams of congratulation and appreciation were read from many state and national figures during the afternoon.

In addition to Chairman Edwards, the State Tuberculosis Board is composed of Mrs. Murray L. Stanley, Daytona Beach, and Dr. Arnold S. Anderson, St. Petersburg. Mrs. May Pynchon, Jacksonville, is secretary.

* * *

MISSISSIPPI HOSPITAL OPENS

The opening of the North Mississippi Community Hospital at Tupelo, Mississippi, on October 3, gives the northeastern part of this state a modern, fireproof, well-equipped 50-bed hospital held in trust for the public,

open to all qualified physicians and designed to serve the sick without discrimination.

This is the eighth such hospital to be built with the aid of the Commonwealth Fund of New York, which is now undertaking to provide one new hospital each year for a predominantly rural community which will agree to meet its share of costs and to run the institution in accordance with generally accepted standards.

The Fund began this project in 1926 as an experiment in meeting the need of rural communities for better medical and other health services. It was known that adequate hospital facilities were lacking in many rural districts, that recent graduates from medical schools were not entering rural practice in proportion to local needs, and that in spite of substantial progress in some parts of the country, health services in rural areas were not so well developed as those usually found in cities. It was assumed that the presence of well planned and well conducted hospitals would to some degree correct this situation, and experience in half a dozen different states indicates that the hope was justified.

The present plan is to aid in establishing hospitals having a capacity of between 25 and 50 beds and easily accessible to a rural community having a population large enough to make good use of such accommodations and capable of meeting operating costs. The hospital may either be a totally new institution, or may replace existing facilities which are clearly inadequate. The Fund furnishes plans, specifications, and architectural supervision for the construction, and not less than $200,000 as a contribution toward capital costs. It advises in the organization of the hospital corporation and the medical staff, offers assistance in meeting the administrative problems of the early years and provides a number of fellowships for postgraduate study by members of the medical staff.

Communities needing a 50-bed hospital are required to raise from $40,000 to $60,000 for their share of the capital cost and must provide in addition a site (with service connections) and from $10,000 to $15,000 to meet the deficit of the first year's operation. Ownership and administrative responsibility are lodged in a local corporation, organized not for profit, which contracts with the Fund to operate the hospital in agreement with specified standards. These standards are such as to guarantee its integrity as a community institution and to justify its approval by the American College of Surgeons.

Hospitals founded under this program are now operating in Murfreesboro, Tennessee; Farmville, Virginia; Glasgow, Kentucky; Farmington, Maine; Wauseon, Ohio; Beloit, Kansas; and Kingsport, Tennessee.

* * *

EXAMINATIONS, AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next examination (written and review of case histories) for Group B candidates who have filed application will be held in various cities of the United States and Canada, on Saturday, February 5, 1938.

The general oral, clinical and pathological examinations for all candidates (Groups A and B) will be conducted by the entire Board, meeting in San Francisco, Cal., on June 13, and 14, 1938, immediately prior to the meeting of the American Medical Association.

Applications for admission to the June 1938 Group A examinations must be on an official application form and filed in the Secretary's Office before April 1, 1938.

For further information and application blanks address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburg (6), Pa.

STATE NEWS ITEMS

Dr. J. M. T. Finney of Baltimore has accepted the invitation to be guest speaker at the annual meeting in Miami. To have on the program and present at the meeting one who not only is an outstanding surgeon of all time, but a man of such lovable character as has Doctor Finney will be a great addition to the many other good things which are going to make the meeting in Miami one of the best to date. The many doctors who have studied and trained under him will be delighted to know that Doctor Finney will be with us, and every doctor in the State of Florida will welcome this opportunity of knowing and hearing him address the Association.

* * *

Tentative plans are being made to hold a sectional meeting of the International College of Surgeons at Tampa in February or March. The following states will be represented in this meeting: Florida, Georgia, Alabama, Mississippi and Louisiana. Details of this sectional meeting will be published later.

Your membership dues were payable January 1. The secretary of your county medical society is a busy doctor. Why not give him your dues promptly?

* * *

Dr. Laura Mae Hobbs of Miami announces the removal of her offices to 404-6 Ingraham Building.

* * *

Dr. Henry Hanson, Lima, Peru, in a recent letter mentioned that "in the Loja investigation there is what one might call a triple problem. We know that there has been plague in the area, a pernicious type of malaria has been reported, and it is possible that I may find 'jungle fever' which is yellow fever transmitted by one or more of the wild mosquitoes found in the jungle."

* * *

Dr. Julius C. Davis, Quincy, was appointed by Governor Fred P. Cone, in December, as a member of the State Board of Medical Examiners to succeed himself.

* * *

Dr. T. Z. Cason of Jacksonville spoke on the Opportunity House radio forum recently. He brought out the relation between the physically underprivileged and crime and pointed out that the health rules and habits which will be taught in the proposed Opportunity House will have their effect in relieving the criminal situation.

* * *

Every practitioner of medicine and surgery holding a license to practice in Florida is required by law to register annually on or before January 1, with the secretary of the State Board of Health, and at that time to pay a fee of $1.00. A licentiate failing to register annually is liable to a fine of not more than $50.00.

Other states having annual registration laws or annual renewal laws are as follows: Arizona, Arkansas, California, Connecticut, Louisiana, Minnesota, New York, North Dakota, Pennsylvania, and Texas.

* * *

Dr. Samuel Aronovitz of Miami recently attended the International Medical Assembly in St. Louis.

Drs. John Dees and A. H. Hinton of Miami have opened new offices at 416-19 Ingraham Building.

* * *

Dr. Noble A. Upchurch, Jacksonville, was elected president of the Florida Public Health Association at its annual meeting in Tallahassee, December 6-8. Dr. L. J. Graves, Tallahassee, was elected first vice-president.

* * *

Dr. E. C. Brunner of Miami has returned from Philadelphia where he took a course of study under Drs. Cutler and Jackson.

* * *

The Thirty-first Annual Meeting of the Southern Medical Association, which closed on December 3 after a four-day session at New Orleans was outstanding in its success. The total registration was 5,258, of which 2,775 were physicians from the southern states comprising the Association. The following 82 members of the Florida Medical Association were in attendance:

Adamson, William P.	Tampa
Andrews, Chadbourne A.	Tampa
Baltzell, N. A.	Marianna
Bartleson, Fred D.	Ft. Myers
Blackmon, H. J.	Tampa
Blake, W. C.	Tampa
Boling, John R.	Tampa
Boothe, R. C.	Ft. Pierce
Borland, J. L.	Jacksonville
Brown, Alan D.	Jacksonville
Carson, Russell B.	Orlando
Cason, T. Z.	Jacksonville
Cleveland, J. Q.	Coral Gables
Cook, George L.	Tampa
Dickinson, J. C.	Tampa
Dozier, L. L.	Tallahassee
Dyer, Walter H.	Tampa
Ferguson, R. D.	Ocala
Fort, Frank L.	Jacksonville
Gainey, J. G.	Blountstown
George, W. W.	West Palm Beach
Glatzau, L. W.	Daytona Beach
Grace, William H.	Ft. Myers
Gurganious, Allen P.	Palatka
Haisfield, A. R.	Pensacola
Harris, Robert M.	Miami
Hodsdon, Benjamin F.	Miami
Holland, Howard G.	Leesburg
Holloway, Luther W.	Jacksonville
Howe, Roy	Daytona Beach
Ingram, L. C.	Orlando
Ira, Gordon H.	Jacksonville
Johnson, Vesey M.	West Palm Beach
Jones, Allan	Miami Beach
Jones, Walter C.	Miami
Kennedy, S. G.	Pensacola
Killinger, Raymond R.	Jacksonville
Kirby-Smith, J. L.	Jacksonville
Koon, Alpheus C.	Lakeland
Lilly, G. D.	Miami
Lisenby, A. H.	Panama City
Litterer, A. B.	Miami
Lovejoy, M. A.	Ft. Lauderdale

McCreary, A. B.	Jacksonville
McIver, Robert B.	Jacksonville
McPhaul, W. A.	Jacksonville
Mabry, C. B.	Jacksonville
Mallory, Meredith	Orlando
Miller, R. L.	Graceville
Mills, Herbert R.	Tampa
Moor, F. Clifton	Tallahassee
Mooty, Ross H.	Winter Haven
Netto, Lloyd J.	West Palm Beach
Norris, S. R.	Jacksonville
Nugent, J. J.	Miami
Oetjen, G. F.	Jacksonville
Owens, J. H.	Jacksonville
Owens, W. Duncan	Miami Beach
Payne, W. C.	Pensacola
Peek, Eugene G.	Ocala
Phillips, Kenneth	Miami
Pickett, W. H.	Pensacola
Quillian, Warren	Coral Gables
Richardson, George W.	Jacksonville
Roberts, S. J.	Miami
Robertson, J. C.	Chattahoochee
Rollins, Clarence D.	Jacksonville
Rowlett, W. M.	Tampa
Royce, Clayton E.	Jacksonville
Shaver, E. F.	Tampa
Smith, DeWitt T.	Gainesville
Smith, H. Mason	Tampa
Stevens, Ralph E.	Chattahoochee
Summitt, R. E.	Gainesville
Taylor, H. Marshall	Jacksonville
Thames, Rufus	Milton
Turberville, J. S.	Century
Veal, Ernest W.	Jacksonville
Webb, Carol C.	Pensacola
Welch, P. B.	Miami
Youmans, C. P.	Miami
Youmans, I. C.	Miami

* * *

The American Medical Association broadcasts each Wednesday from 2 to 2:30 p. m., the programs consisting of dramatized health messages. During the coming month, the following topics will be handled:

Jan. 26—Poliomyelitis: information about the disease; cooperation with President's Birthday Ball.

Feb. 2—Rheumatism and Arthritis: known factors in the causation of arthritis and its care.

Feb. 9—Healthy Hearts and Arteries: known ways of protecting the heart against infection and hygienic abuse; how to live with heart disease.

Feb. 16—Don't Fear Cancer—Fight It: known factors in the cause, prevention and treatment of cancer.

Feb. 23—Overcoming Diabetes: individual efforts plus medical aid will win against diabetes.

COMPONENT COUNTY SOCIETIES

BROWARD COUNTY MEDICAL SOCIETY

The annual election of officers was held by the Broward County Medical Society on the evening of December 22. The following officers were elected for 1938: President—A. B. Connor, Ft. Lauderdale; Vice-President—Robert E. Blount, Ft. Lauderdale; Sec'y-Treas.—O. C. Brown, Ft. Lauderdale.

Drs. L. F. Robinson and George McClellan were elected to serve as delegates to the next meeting of the State Association.

* * *

DADE COUNTY MEDICAL SOCIETY

At its meeting held on the evening of December 7, the members of the Dade County Medical Society elected the following officers for 1938: President—Arthur H. Weiland, Coral Gables; Vice-President — Frazier J. Payton, Miami Beach; Secretary — Claude G. Mentzer, Miami; Treasurer — Scheffel Wright, Miami.

* * *

DUVAL COUNTY MEDICAL SOCIETY

The January meeting of the Duval County Medical Society was held at the State Board of Health Building, at 8:15 p. m., January 4. The following papers constituted the scientific program: "Protamine Zinc Insulin in the Treatment of Diabetes Mellitus"— Louie M. Limbaugh and Karl Hanson; discussors—T. Z. Cason and Luther Holloway.

"Arthus's Phenomenon from Mosquito Bites" (illustrated by lantern slides)—Alan Brown; co-authors—T. H. D. Griffitts, Stanley Erwin and Lucien Dyrenforth.

* * *

ESCAMBIA COUNTY MEDICAL SOCIETY

The Escambia County Medical Society, at a recent meeting, held its election of officers for 1938, which resulted as follows: President—J. H. Hoffman, Pensacola; Vice-President—J. S. Turberville, Century; Sec'y-Treas.—J. N. McLane, Pensacola.

During December this society paid the last of its outstanding dues for 1937, thus joining the ever-growing list of societies which are on the Honor Roll for 1937.

HILLSBOROUGH COUNTY MEDICAL SOCIETY

The Hillsborough County Medical Society recently held its election of officers for 1938, at which time the following were chosen to head the organization: President—Joseph W. Taylor, Tampa; Vice-President—Ralph S. Torbett, Tampa; Sec'y.-Treas. — James S. Grable, Tampa. Delegates to Fla. Med. Assn. —W. M. Rowlett, William C. Blake, H. Mason Smith, J. W. Alsobrook, and John R. Boling.

* * *

JACKSON COUNTY MEDICAL SOCIETY

The Jackson County Medical Society, at a recent meeting, elected the following officers to serve for 1938: President—D. A. McKinnon, Marianna; Vice-President—J. G. Gainey, Blountstown; Sec'y.-Treas.—R. N. Joyner, Marianna. Dr. Lewis Pierce was elected delegate to the State Association and Dr. C. D. Whitaker, alternate delegate.

* * *

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

The Pasco-Hernando-Citrus County Medical Society met at Inverness Thursday, December 9, with Dr. Claude L. Carter as host. A full course steak dinner was served at the Orange Hotel followed by the scientific meeting at Doctor Carter's home.

Action was taken to postpone the election of officers until the next regular meeting. Dr. W. S. Hancock was reelected to membership in the society. Interesting case reports were given by Drs. Claude Carter, G. R. Creekmore, S. C. Harvard, H. L. Harrell, P. J. Hudson, W. S. Hancock and W. H. Walters. In addition to those who presented case reports, Drs. George A. Dame and W. H. Cox were present. The next regular meeting will be held January 13, 1938, at Brooksville with Dr. G. R. Creekmore as host.

* * *

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society held its semi-monthly meeting on December 3 at the Park Inn, Clearwater Beach. The following papers constituted the scientific program: "Ileitis"—J. D. Hagood, Clearwater; "B. Violaceus Infection—Case Report"—M. E. Black, Clearwater.

ABSTRACT DEPARTMENT

Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.

An Unusual and Interesting Case Report—Russell, Ralph E., Ocala, *Eye, Ear, Nose & Throat, Month.*, January, 1937.

The author reports a benign myxofibroma, unusual in its origin and position.

The patient, a negro girl of twenty, gave no history of sinus pathology prior to the complaint of pain in the left upper teeth and swelling of the gums in this region in 1932. Six months later she became conscious of something growing inside the mouth in the region of the offending teeth. This was followed by a gradual increase in size until observed by the author 2½ years later. At this time the tumor was quite large and definitely pedunculated with the pedicle situated in the left antrum. Two months later the increase in size had been sufficient to seriously interfere with nourishment and the patient, who had previously refused, now consented to operation. This, preceded by transfusion of whole blood, was performed under general anesthesia and the mass, weighing nearly two pounds, was removed in one piece. The entire floor of the left antrum with the dental arch was absent and the antrum was entirely filled by the tumor pedicle. Aside from some surgical shock, the patient's recovery was uneventful.

Steatocystoma Multiplex—Mount, Louis B., St. Petersburg, *Arch. Dermat. & Syph.*, 36: 31-39 (July) 1937.

Steatocystoma multiplex is a relatively rare dermatological condition characterized by the formation, in regions of lanugo, of varying sized, small nonsensitive cystic tumors involving the pilosebaceous apparatus without change in appearance of the surrounding skin. These tumors vary from millet seed to cherry size and are attached to the overlying skin. The color varies from that of natural skin to yellow or blue. On incision of the cyst there exudes a colorless or yellow, opaque, odor-



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less, greasy and more or less fluid substance.

Various views as to formation are presented, the most plausible being a blockage of the excretory passage of the sebaceous gland with a consequent gradual dilatation of the duct or follicle which continues until atrophy of the gland itself takes place through pressure. All authors (with one exception) believe that the gland itself is not involved in the cyst structure.

Pathologically, the epithelium over the larger cysts is thinned, the rete pegs are flattened and there is keratinization of the follicles. The cysts, at various levels in the coreum, are composed of an epithelial inner layer, identical with the cells of the sebaceous gland ducts and an outer circular connective tissue sheath. The contents, representing the simple secretion of the sebaceous gland is always pure fat.

A case, in a girl of 21, is reported by the author.

Management of Atonic Bladder Due to Obstruction of Vesical Neck—ORR, LOUIS M., II, Orlando, *South. M. J.*, 30:519-524 (May) 1937.

Due to the anatomical nature of the bladder which the author reviews, formation of diverticulae of this organ are easy to understand. Diverticulae are associated with atony. Atony, however, may be primary, i. e., due to interference of the nerves to the detrusor muscles, or secondary to obstructive lesions at the vesical neck or in the urethra. Such secondarily atonic bladders are irregular in shape on the cystogram and on inspection show areas of hypertrophied muscle fibres interlacing through thin-walled membranous areas of the bladder.

Treatment of this type of atonic bladder due to obstruction lies first in the removal of the obstruction whether it be an enlarged prostate, a stricture, or other urethral obstruction. After the obstruction has been removed the atonic bladder is aided in recovering its muscular power by means of persistent catheterization or continuous indwelling catheter until the bladder is strong enough to empty itself without leaving residual urine. The author reports one case in which atony was so marked that the muscle fibres had no recuperative power in a large part of the bladder. A large segment was resected, so that the remaining fibres were able to resume some function.

Studies on the Neutralization Test of Gastric Acidity in Relation to General Disease—PHILLIPS, KENNETH, Miami, *Am. J. Digest. Dis. & Nutrition*, 4:87-91 (April) 1937.

The value of the neutralization test of gastric acidity is well established in cases of ulcer but its value in other gastrointestinal conditions has not been studied. Before making such studies the author devised a modification of the original method; instead of 300 cc. of 0.6% HCL he uses 150-200 cc. of 0.5% HCL, with more frequent withdrawals of larger amounts of the gastric fluids, thereby reducing the factors of overdistension of the stomach and its resultant nervousness and vomiting.

As a result of his studies the author finds that neutralization of stomach contents can be as rapid in cases of pyloric obstruction as where the stomach empties rapidly and that the only correlation seems to be the extent of the pathologic changes. His curves also reveal that the neutralizing power of the gastric contents is entirely independent of its secretory activity. He concludes that regurgitation of duodenal fluids into the stomach is not enough to explain this neutralizing power of the stomach; that while it plays the main part, other factors such as dilution must also be considered.

From the author's studies he also concludes that the neutralization test of gastric acidity is valuable only in ulcer and pylorospasm; that it has no value in other gastrointestinal disturbances, except perhaps liver and gallbladder disease.

Florida's Climate—An Everlasting Lure—SCHLERNITZAUER, BOB, Rockledge, *Florida Grower*, Sept., 1937, p. 6.

In a reminiscent vein, the author extols the virtues of the Florida climate, calling particular attention to the neglected summer phase and the health promoting qualities of the prolonged sunshine and the relative freedom from humidity.

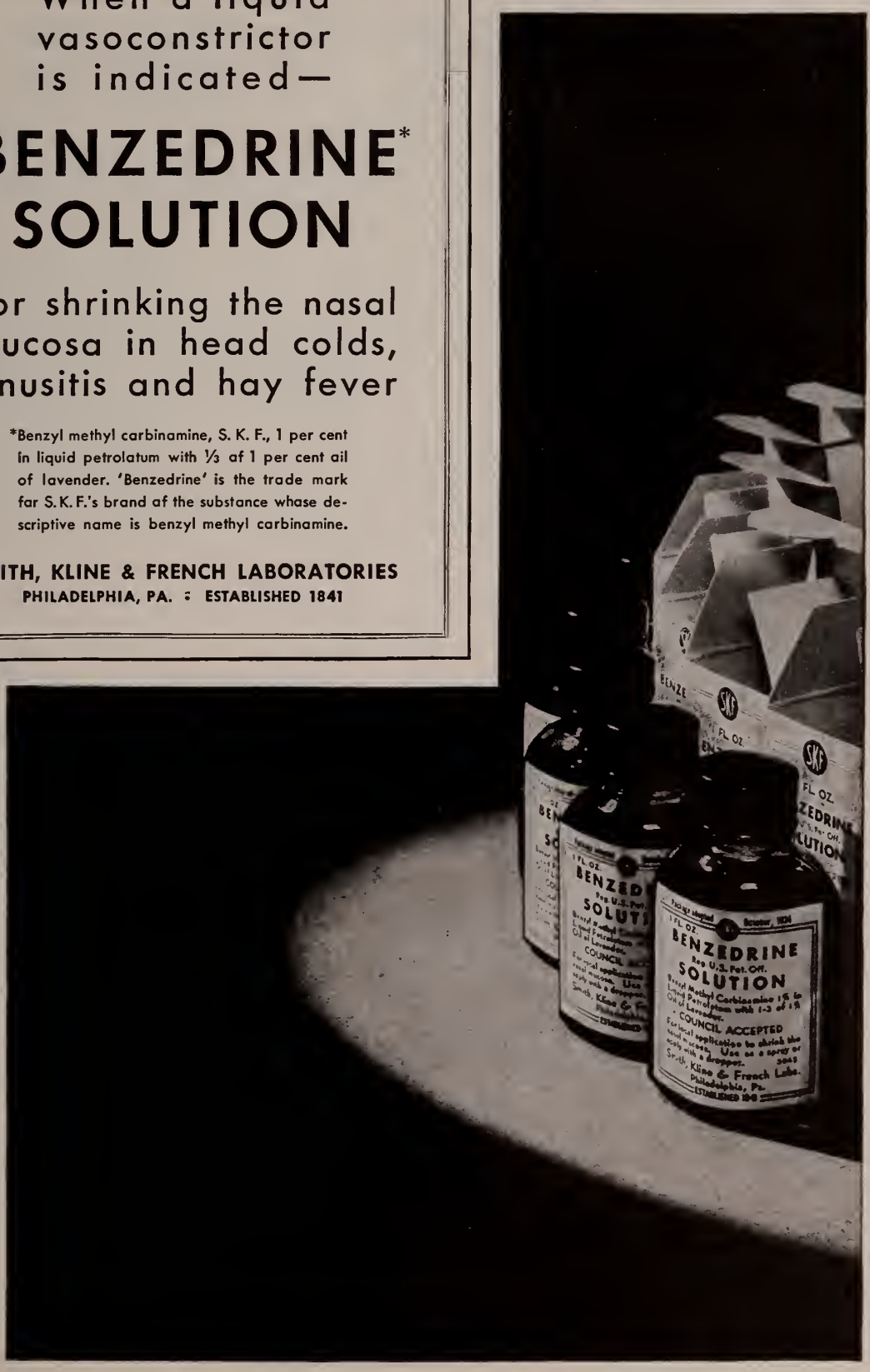
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WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, INC.

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Jacksonville

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SOUTHERN NEWS

The fourteenth annual meeting of the Woman's Auxiliary to the Southern Medical Association was held in New Orleans, November 30 to December 3, 1937. Much credit and praise is due members of the Orleans Parish Medical Auxiliary for the delightful entertainment, Mrs. E. W. Veal of Jacksonville reports.

Mrs. Frank N. Haggard, President of the Southern Medical Auxiliary, called the Executive Board to a breakfast given with the compliments of the Southern Medical Association. The business brought up was brief—election of the Nominating Committee and a discussion of the duties of state Councils. Under the Constitution adopted in Baltimore last year, the Executive Board includes the elected officers and one counselor appointed from each state.

The first general session of the Auxiliary followed with Mrs. Haggard presiding. After the invocation a very lovely In Memoriam service was conducted by Mrs. H. B. Gessner of New Orleans. Mrs. George J. Taquino, General Chairman of the Committee for Ladies Entertainment, welcomed the visitors and Mrs. William Hibbitts of Texarkana, Ark., responded. Greetings from the Orleans Parish Auxiliary and the Louisiana State Auxiliary were extended by their respective presidents, Mrs. Jules Myron Davidson and Mrs. George D. Feldner, both of New Orleans. Mrs. Augustus S. Kech, President of the national auxiliary, brought greetings and told about the work of her own auxiliary in Pennsylvania.

The Chairman of the Jane Todd Crawford Committee, Mrs. T. R. W. Wilson of Green-

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ville, S. C., described the plans which are being made for some type of living memorial and the interest in it by most of the states. Mrs. S. A. Collom, Chairman of the Research and Romance of Medicine Committee, gave her report in the form of a Booklet of Suggested Programs for the County Auxiliaries. This booklet may be obtained from your State President.

The annual luncheon was held the next day when the president, Mrs. Haggard, turned the meeting over to the toastmistress, Mrs. W. K. West. Dr. Seale Harris of Birmingham, a member of the Advisory Committee, talked on the life and work of Dr. James Marion Sims, the famous southern doctor whose study and operations on his three slaves did so much for the advancement of gynecology. Dr. Frank K. Boland of Atlanta, President of the S. M. A. spoke of the life and work of Dr. Crawford Long, the southern doctor who first used ether. The next speaker, Mrs. Augustus S. Kech, gave a talk on the wives of these doctors, showing their devotion and the influence they had on the work and lives of their famous husbands.

The report of the Courtesy and Resolutions Committee was given by the Chairman, Mrs. Eugene Peek of Ocala.

The report of the Nominating Committee resulted in the election of the following officers for the year 1937-38:

President, Mrs. Luther Bach, Bellevue, Ky.; President-elect, Mrs. W. K. West, Oklahoma City, Okla.; 1st Vice-Pres., Mrs. T. R. W. Wilson, Greenville, S. C.; 2nd Vice-Pres., Mrs. E. W. Veal, Jacksonville, Fla.; Rec. Sec., Mrs. E. H. Hargis, Birmingham, Ala.; Treasurer, Mrs. George J. Taquino, New Orleans, La.; Historian, Mrs. J. W. Warren, New Orleans, La.; Parliamentarian, Mrs. M. Pinson Neal, Columbia, Missouri.

* * *

ALACHUA COUNTY

The Alachua County Auxiliary was entertained at a dinner at the Florida Farm Colony in December. After a short business meeting, a program was given by members of the Farm Colony showing their educational and leisure activities.



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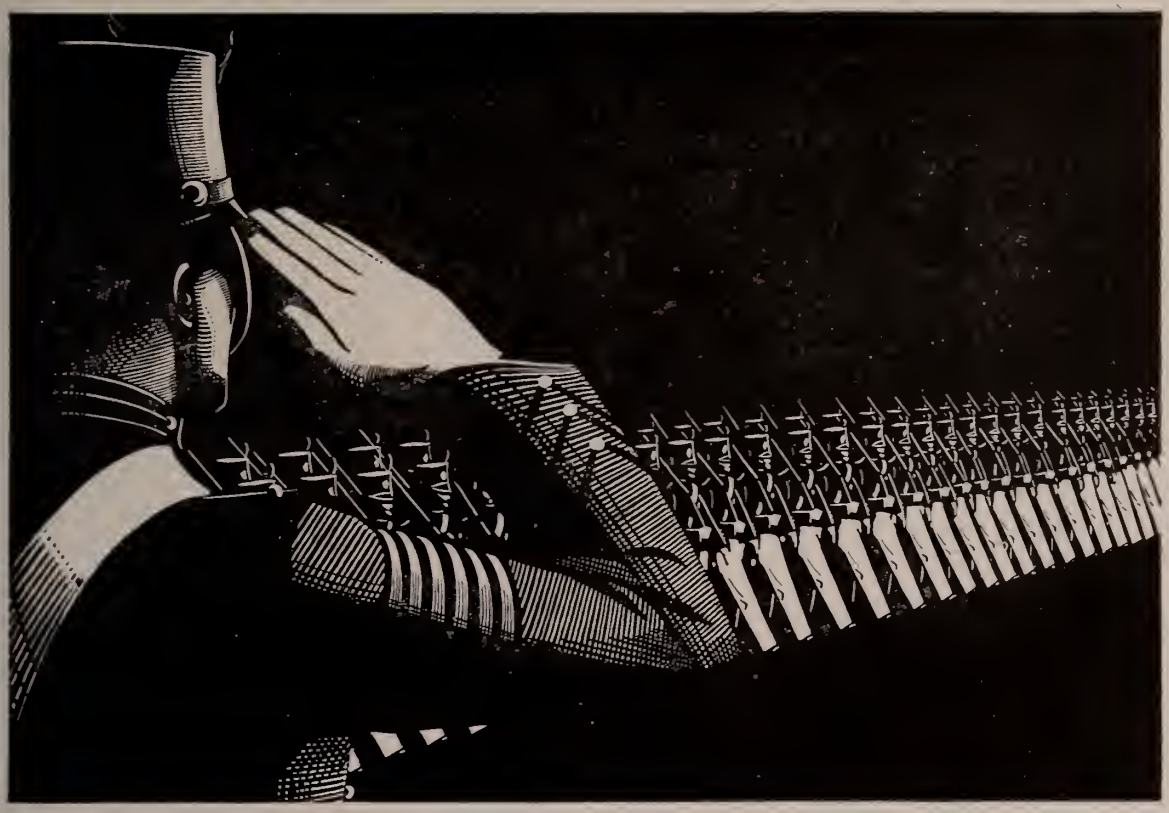
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PINELLAS COUNTY

At the December luncheon meeting of the Pinellas County Auxiliary, Dr. C. S. Franckle gave a discussion of cancer and its problems to physicians. Mrs. Paul Penningroth explained the aims and purposes of the Mother's Health Center. The Auxiliary voted to endorse the clinics held by this organization and to contribute to the Empty Stocking Fund. Fifteen members were present.

At a special meeting of officers and committees it was decided to bring to St. Petersburg in the spring an A. M. A. motion picture on "Cancer," the presentation of which will be open to the public.

* * *

VOLUSIA COUNTY

The December meeting of the Woman's Auxiliary of Volusia County was held in Daytona Beach at the Morgan Hotel. Ten members and six guests sat down to dinner. A short business meeting followed with the president, Mrs. P. W. Henry of New Smyrna, presiding.

BOOKS RECEIVED

Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.

MENTALITY AND HOMOSEXUALITY. By SAMUEL KAHN, B. S., M. A., Ph. D., M. D., formerly on the Psychiatric Staffs of Kings County and Kings Park State Hospitals, New York; New York County Penitentiary, and Sing Sing State Prison, New York. Deals with the methods of getting certain information and also with mental, psychological, physical and sociological factors which appeared to be the most prominent characteristics in a large group of homosexuals, all of whom were incarcerated in a special division of the N. Y. Penitentiary for men and the Women's Workhouse and Correction Hospital for women. Many educational, endocrinological and psychoanalytical aspects are considered. Cloth. Price $3.00. Pp. 249. Meador Publishing Company, Boston, Mass.

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*Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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*Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245 ☐ Laryngoscope, 1935, XLV, 149-154 ☐
N. Y. State Jour. Med., 1935, 35, No. 11, 590 ☐ Laryngoscope, 1937, XLVII, 58-60 ☐

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STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Edward Jelks, Jacksonville	Shaler Richardson, Jacksonville	Miami, May 9-11, 1938
Florida Medical Districts:			
A—Northwest	J. S. Turberville, Century	Stewart Thompson, Jacksonville	Panama City, July 14, 1938
B—North Central	A. B. Albritton, Wildwood	" " "	Gainesville, Oct. 27, 1938
C—Northeast	Hugh West, DeLand	" " "	Ponte Vedra, Sept. 15, 193
D—Southwest	J. A. Simmons, Arcadia	" " "	Bradenton, Sept. 29, 1938
E—South Central	W. C. Page, Cocoa	" " "	Leesburg, Nov. 10, 1938
F—Southeast	F. K. Herpel, West Palm Beach	" " "	Ft. Lauderdale, October 13
Alabama Medical Association	E. S. Sledge, Mobile	D. L. Cannon, Montgomery	Mobile, April 19-21, 1938
Georgia Medical Association	George A. Traylor, Augusta	E. D. Shanks, Atlanta	Augusta, April 26-29, 1938
Am. Urol. Assn. (Southeastern Br.)	George Livermore, Memphis	Raymond Thompson, Charlotte, N. C.	Louisville, Dec. 2, 3, 1938
Florida—			
State Dental Association	R. D. Cummins, St. Petersburg	Lloyd Harlow, Bradenton	Jacksonville, 1938
Soc. of Derm and Syph.	J. L. Kirby-Smith, Jacksonville	Wiley Sams, Miami	Miami, May 9, 1938
East Coast Medical Association	Walter C. Jones, Miami	T. C. Kenaston, Cocoa	Melbourne, 1938
State Hospital Association	Mr. T. S. Alexander, Tampa	Mr. Fred Walker, Jacksonville	Birmingham, April 7-9, 193
Medical Postgraduate Course	Turner Z. Cason, Jacksonville, Chairman		
Midland Medical Society	W. C. McConnell, St. Petersburg	B. H. Sanchez, Plant City	Orlando, April 28, 1938
State Nurses Association	Mrs. Inez Nelson, Orlando	Mrs. Phyllis Leonard, St. Augustine	Sarasota, 1938
Pediatric Society	Douglas D. Martin, Tampa	Warren Quillian, Coral Gables	Miami, May 9, 1938
Pharmaceutical Association	Mr. R. Q. Richards, Ft. Myers	Mr. A. W. Morrison, Miami	
Radiological Society	Gerard Raap, Miami	H. B. McEuen, Jacksonville	Miami, May 9, 1938
Railway Surgeons' Association	J. R. Wells, Daytona Beach	H. D. Clark, Ft. Pierce	Miami, May 9, 1938
Chattahoochee Valley Med. Assn.	J. J. Clark, Atlanta	Frank K. Boland, Atlanta	Albany, Ga., July 12, 13, 19
Gulf Coast Clinical Society	H. L. Bryans, Pensacola	J. H. Baumhauer, Mobile, Ala.	Pensacola, 1938
Seaboard Railway Surgeons' Assn.	Joseph D. Collins, Norfolk	J. W. Palmer, Ailey, Ga.	December, 1938
Southeastern Derm. Assn.	J. L. Kirby-Smith, Jacksonville	Joe Elliott, Charlotte, N. C.	Charlotte, Sept., 1938
Southeastern Surgical Congress	Fred W. Rankin, Lexington, Ky.	B. T. Beasley, Atlanta	Louisville, March 7-9, 1938
Southern Medical Assn.	Frank K. Boland, Atlanta	Mr. C. P. Loranz, Birmingham	Oklahoma City, 1938
Suwannee River Medical Society	W. M. Ives, Lake City	H. S. Howell, Lake City	



COMPONENT SOCIETIES BY DISTRICTS—FLORIDA MEDICAL ASSOCIATION

Districts	COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR *and Counties Not Included in First Column*	Members Total	Members Paid
	Bay	D. M. Adams, M. D., Panama City	Allen H. Miller, M. D., Millville		A-1-'38 John S. Turberville, M. D., Century	12	
	Escambia	J. M. Hoffman, M. D., 1221 E. DeSoto St., Pensacola	J. N. McLane, M. D., 204 W. Brainard St., Pensacola	2nd Tuesday 8:00 P. M.		39	
	Walton-Okaloosa	A. G. Williams, M. D., Lakewood	R. B. Spires, M. D., DeFuniak Springs	3rd Thursday 8:00 P. M.		5	
	Washington-Holmes	B. W. Dalton, M. D., Vernon	R. H. Segrest, M. D., Bonifay		*Santa Rosa*	7	
	Jackson	D. A. McKinnon, M. D., Marianna	R. N. Joyner, M. D., Marianna	2nd Tuesday 7:30 P. M.	A-2-'39 N. A. Baltzell, M. D., Marianna	14	9
	Leon-Gadsden-Liberty-Wakulla-Jefferson	W. D. Rogers, M. D., Chattahoochee	B. A. Wilkinson,, M. D., Telephone Bldg., Tallahassee	Quarterly 3:00 P. M.	*Calhoun-Franklin-Gulf*	37	
	Columbia	William S. Nichols, M. D., Lake City	Harry S. Howell, M. D., Blanch Hotel Annex, Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M. D., Lake City	12	8
	Madison	E. Long, M. D., Madison	Geo. O. Davie, M. D., Madison			4	
	Taylor	G. H. Warren, M. D., Perry	J. C. Ellis, M. D., Perry	Last Friday 8:00 P. M.	*Baker-Dixie-Hamilton-Lafayette-Suwannee*	8	
	Alachua	T. A. Snow, M. D., 103 E. University Ave., Gainesville	H. M. Merchant, M. D., 124 E. University Ave., Gainesville	2nd Friday 7:30 P. M.	B-4-'38 A. B. Albritton, M. D., Wildwood	25	
	Marion	Carney W. Mimms, M. D., Commercial Bank Bldg. Ocala	R. C. Cumming, M. D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P. M.		22	11
	Pasco-Hernando-Citrus	W. Wardlaw Jones, M. D., Dade City	G. R. Creekmore, M. D., Brooksville	2nd Thursday 7:00 P. M.		13	
	Sumter	A. B. Albritton, M. D., Wildwood	W. E. Mitchell, M. D., Bushnell	2nd Tuesday	*Bradford-Gilchrist-Levy-Union*	4	
	Duval	J. Lunsford Boone, M. D., 500 Professional Bldg., Jacksonville	George W. Croft, M. D., 713 Greenleaf Bldg., Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shew, M. D., Jacksonville	162	3[illegible]
	St. Johns	Charles C. Grace, M. D., East Coast Hospital, St. Augustine	R. D. Harris, M. D., St. Augustine	3rd Tuesday 8:30 P. M.	*Clay-Nassau*	11	
	Putnem	H. A. Johnson, M. D., Palatke	F. Emory Bell, M. D., Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'33 Hugh West, M. D., DeLand	10	
	Volusia	Hugh West, M. D., DeLand	R. L. Miller, M. D., 258½ S. Beach St., Daytona Beach	2nd Tuesday 7:30 P. M.	*Flagler*	40	
	Hillsborough	Joseph W. Taylor, M. D., 706 Franklin St., Tampa	James S. Grable, M. D., 811 Citizens Bank Bldg., Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M. D., Plant City	102	35
	Manatee	John F. Mason, M. D., Bradenton	M. M. Harrison, M. D., Bradenton	3rd Tuesday 7:00 P. M.		12	
	Pinellas	J. A. Strickland, M. D., 712 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D., 1005 Equitable Bldg., St. Petersburg	1st and 3rd Fridays 6:30 P. M.		88	58
	Sarasote	O. H. Cribbins, M. D., 224 Commercial Court, Sarasota	J. E. Herris, M. D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P. M.		18	
	DeSoto-Hardee-Highlands	Gordon H. McSwain, M. D., Arcadia	L. W. Martin, M. D., Sebring	2nd Tuesday 8:00 P. M.	D-8-'38 J. A. Simmons, M. D., Arcadia	19	
	Lee	H. Quillian Jones, M. D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M. D., 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P. M.		13	
	Polk	W. W. Shafer, M. D., Haines City	J. R. Boulware, Jr., M. D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	*Charlotte-Collier-Glades-Hendry*	61	
	Brevard	W. C. Page, M. D., Cocoa	Bob Schlernitzauer, M. D., Rockledge	3rd Tuesday	E-9-'38 W. C. Page, M. D., Cocoa	10	
	Lake	Harry T. Fenn, M. D., Mount Dora	W. L. Ashton, M. D., Umatilla	1st Thursday 12:30 P. M.		17	
	Orange	F. H. Harms, M. D. 64 No. Court St., Orlando	Howitt Johnston, M. D., Box 2002 Orlando	3rd Wednesday 8:30 P. M.		63	
	Seminole	J. N. Tolar, M. D., Sanford	Douglee G. Scott, M. D., Box 489 Sanford	2nd Monday 7:00 P. M.	*Osceola*	13	
	St. Lucie-Okeechobee-Indian River-Martin	H. D. Clark, M. D., Bank & Trust Bldg. Ft Pierce	Grover C. Hardie, M. D., 207½ Orange Ave. Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M. D., Ft. Pierce	13	
	Browerd	A. B. Connor, M. D., Sweet Bldg., Ft. Lauderdale	Oliver C. Brown, M. D., 915 Sweet Bldg., Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'38 F. K. Herpel, M D., West Palm Beach	31	
	Palm Beech	Bailey B. Sory, Jr., M. D., Brazilian Court Hotel, Palm Beach	Lloyd J. Netto, M. D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P. M.		55	
	Dade	Arthur H. Weiland, M. D., 227 Aragon Ave., Coral Gables	Claude G. Mentzer, M. D., 808 Huntington Bldg., Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M. D., Miemi Beach	260	
	Monroe	Harry C. Galey, M. D., 532 Fleming St., Key West	W. R. Warren, M. D., 511 Eaton St., Key West	1st Sunday 9:00 P. M.		3	



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Southern Medical Association, Oklahoma City, 1938.

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In contrast to the other vitamin deficiencies, cases of severe deprivation of the anti-pellagric factor are not uncommon in certain regions of the United States. It is also known that if the intake of food be drastically restricted for some reason—alcoholism, for example—pellagra may be encountered in localities in which the disease is not endemic (1). For these reasons, it is not unreasonable to suspect that subacute or latent deficiencies of the P-P factor may also be existent in this country.

In the absence of typical dermatitis, available means for the diagnosis of deficiencies of the anti-pellagric factor are not entirely satisfactory. The practitioner must rely upon a variable group of less specific symptoms such as glossitis, diarrhea, digestive disturbances, and nervous and mental disorders. However, consideration of these symptoms along with an evaluation of the diet upon which the subject had been maintained, may permit the conclusion that suboptimal intake of the P-P factor should be suspected.

The treatment of severe or perhaps even the mild manifestations of this dietary deficiency may require intensive therapy with food products or preparations known to be rich in the pellagra preventing factor. However, prevention of pellagra and maintenance of the cure appear to be largely matters of dietary regulation. In this connection, commercially canned foods deserve particular mention.

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1. 1937. J. Am. Med. Assn. 108, 15. 1935. Ibid. 104, 1377.

2. 1934. U. S. Pub. Health Rpts. 49, 755.

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How much more likely, then, that rickets will develop among city-bred children who live under a smokepall for a large part of each year. True, vitamin D is more or less routinely prescribed nowadays for infants. But is the antiricketic routinely administered in the home? Does the child refuse it? Is it given in some unstandardized form, purchased from a false sense of economy because the physician did not specify the kind?

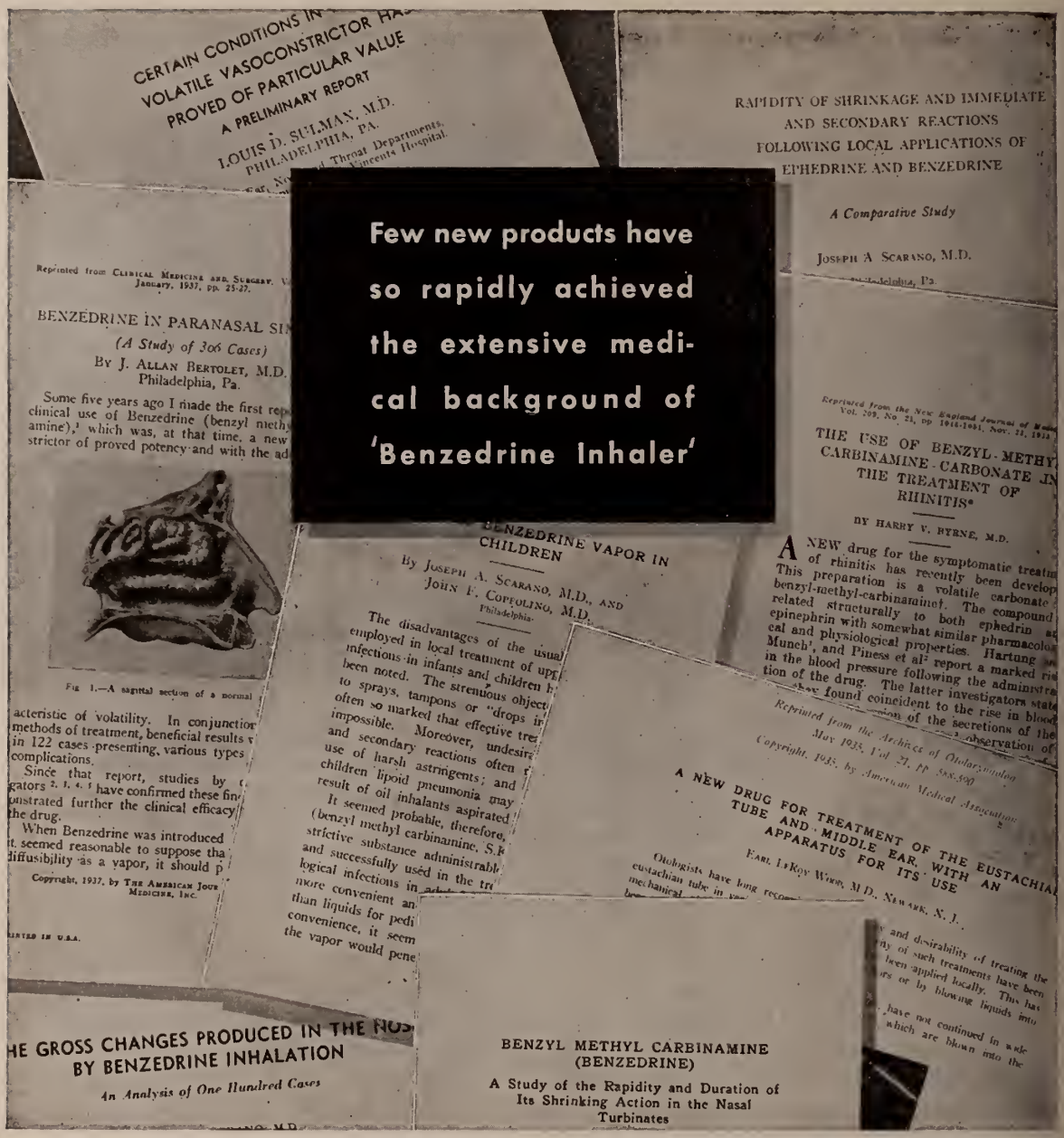
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N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
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GONORRHEAL ARTHRITIS*

CHARLES R. BURBACHER, M.D., and
ARTHUR H. WEILAND, M.D.
Coral Gables

Inflammatory joint manifestations coincident with gonorrhea were first noted by Pierre Van Forest, in 1507, when he described a case of gonorrhea with swelling of the knee. Selle in 1781 said that gonorrheal matter can cause articular pain and in 1786 John Hunter wrote of a gentleman who had rheumatic pains with each attack of gonorrhea. Swediour, in his treatise on Syphilis published in Philadelphia in 1815 wrote as follows: "A very considerable swelling of the knee (sometimes of both knees and heels at once) sometimes occurs in men with blennorrhagia. These pains, accompanied by more or less symptomatic fever, continue for two or three weeks and gradually go off leaving a stiffness in the joints which lasts for many months."

Fournier later presented a treatise in answer to various arguments advanced in the French Academy of Medicine, in which he insisted that gonorrheal urethritis was the essential, direct and necessary cause of gonorrheal arthritis and that if there were no gonorrhea there was no gonorrheal arthritis. The gonococcus was described by Neisser in 1879, and shortly thereafter the organisms were recovered from joint effusion, thus definitely proving that arthritis was caused by migration of gonococci from the site of primary infection.

At the present time, medical thought is agreed upon one fact, that gonorrheal arthritis is a definite disease entity and that it arises as the most frequent extra-genito-urinary complication. As to the treatment and clinical conduct of the disease, however, such is not the case. It is also generally accepted that the incidence of arthritis as a metastatic complication of gonorrhea averages from two to three per cent of all cases. Males are much more frequently affected than females, in the ratio of about ten to one. The joint manifestations usually come on during the second or third week of the acute stage of a gonococcic infection; however, they may occur during any period of the acute or subacute stages. The ratio of monarticular involvement to polyarticular infection is about two to three. In fifty-eight cases observed by the essayists, the joints involved, in order of frequency, were as follows: knee, metatarsal, ankle, metacarpal, wrist, hip, elbow, sacroiliac, shoulder, sternoclavicular, temperomandibular. Infections of the knee constituted forty-four per cent of the total joints involved.

The symptomatology of gonorrheal arthritis is very much the same as in any other acute or subacute infectious arthritis. Pain is a constant manifestation. Periarticular swelling and effusion in the joint are present in varying degrees. Fever in the acute stages ranges from one hundred degrees to one hundred and three degrees. These findings in the presence of an acute or subacute gonorrheal urethritis or salpingitis, together with the recovery of the gonococcus from the joint effusion, make the diagnosis infallible.

The therapeutic measures employed in its treatment are legion, which, in itself, is sufficient evidence to impress one with the fact that as yet no common satisfactory or specific therapy which meets all requirements, has been described. Therapeutic measures to date have included: immobilization varying from bed rest to extensive plaster casts, splints and traction; no limitation of activity; local applications of many types; counter-irritants; ice; heat; diathermia; x-ray therapy; various therapeutic light treatments; aspiration and re-injection with various chemical solutions, such as formaldehyde and glycerine, tincture of iodine, acriflavine, etc.; antiserums; gonophages; arthrotomy, with or without lavage; autogenous and stock vaccines; various drugs intravenously; and a host of others too numerous to note. Fever therapy, either of the anaphylactic type, using typhoid vaccine and

*Read before the Sixty-fourth Annual Meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, 1937.

foreign protein or by use of the recently developed hypertherm, has proved to be of definite value. Severe polyarticular cases are especially benefited by the use of the hypertherm in competent hands.

In 1932 this type of arthritis was discussed by one of us with Doctors Holmes and Coplan of Miami, at which time they spoke of the use of rivanol in the treatment of gonorrheal urethritis. The possibility of its use in joints at that time was suggested. In reviewing the literature, it was found that Klapp had recently used a solution of rivanol of a definite strength in the treatment of gonorrheal arthritis by periarticular injections. He succeeded at times in improving joints in the acute and subacute stages by only one injection. He also found that the rivanol had no apparent harmful effects when injected into living tissue. Hence, after noting these facts, it was decided, in our practice, to inject directly into the joint cavity a known strength of rivanol solution after first aspirating the excessive effusion. The results have been most pleasing.

More recently, in order to avoid some of the disagreeable pain and irritative effects which temporarily accompany the injection, novocain has been added to the rivanol solution, which has made the procedure practically without pain. Rivanol is the name for ethyloxy-diamino-acridinium hydrochloride. It is marketed in the lactate form and put up in capsules containing .1 Gm. of rivanol and 2 Gm. of dextrose. A one-half per cent solution in distilled water is freshly prepared at the time of injection. The quantity necessarily varies with the joint to be treated. One per cent novocain solution may be used as the diluent. The affected joint is aspirated, removing all fluid possible, employing the usual sterile technique, and a specimen preserved for culture. The rivanol solution may then be injected through the same needle, the quantity being about one-third less than that aspirated, to avoid painful distension of the joint capsule. It follows that the anticipated capacity of the joint determines the amount of solution that one must prepare. Following injection, the extremity is placed in a comfortable position, either in a sway or on pillows. In ginglymus joints there is a tendency to assume an attitude of flexion which should be discouraged. Light traction or sand-bags may be necessary to overcome this tendency. No difficulty has been noted from injection of this solution into the periarticular tissues.

With this procedure, in the experience of the essayists, the acute symptoms are aborted in sixty per cent of acute cases within forty-eight hours. Relief of symptoms is noted in ninety-five to ninety-eight per cent of all acute cases. If necessary, this procedure may be repeated at intervals of three or four days. However, usually one injection is adequate. It is our opinion that the promptness of relief of symptoms is directly proportional to the acuteness of the case. The more chronic the condition, the less effective will be the treatment.

Case report: B. F. Male, aged 27, presented a case of acute gonorrhea with urethral discharge of 14 days' duration. He had been under urological treatment for 8 days. On the 14th day, pain developed in the right ankle which subsequently became markedly swollen and painful. His temperature was 101.6° F. Diagnosis: Gonorrheal arthritis, right ankle. On the following day, the ankle joint was aspirated and 8 cc. of rivanol and dextrose solution injected. This was followed by complete relief of symptoms in 24 hours and the patient left the hospital. One week later, against the advice of his physician, he was married. Two weeks later his wife entered the same hospital with a diagnosis of gonorrheal salpingitis and arthritis of the left wrist. She was also subsequently treated in the same manner and made an uneventful recovery.

SUMMARY

1. Gonorrheal arthritis is the most frequent extra-genito-urinary complication of acute gonorrhea.

2. In its treatment, many and varied measures have been employed, none of which is in any great degree satisfactory.

3. The therapy as advocated by the essayists has, in their experience, been more adequate than any other employed.

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227 Aragon Ave.

DISCUSSION

Dr. Prescott LeBreton, St. Petersburg:

The orthopedic man usually receives these cases of gonorrheal arthritis after a great deal of damage has been done and stiffness with deformity is present. It is very fine when we can get a case of this kind early.

As I understand it, the infection first is limited inside of the joints and it takes considerable time to get outside the joints and the joint tissues. Some years ago, I read a paper on washing out by the Cotton method, citing a good many cases which are rather startling in their after results. Some of those cases were gonorrheal in type. The Cotton method is very effective in my hands. In early treatment, anything that would add to the early cure of the gonorrhea satisfies because the late efforts are so very ineffectual.

I shall certainly be glad to try rivanol. My one comment was: what would be the matter with making an incision of half an inch, getting rid of most of the infection, and leaving in the joint a certain amount of the rivonal itself. I am certain the other members of the Association will be glad to try this method.

Dr. Gordon H. Ira, Jacksonville:

I would like to say a word about a cabinet that I have. I believe that Dr. Weiland's last remark was that fever therapy was most successful.

I have built a cabinet that has been very successful in the treatment of gonorrheal arthritis. This cabinet is just a small room, large enough to stand in, with a wooden table or cot and mattress, with an opening at the head of the cot through which the patient's head protrudes. There is a heat tunnel starting under the bed, and runs so that hot air is blown on to the patient, making him more comfortable.

An industotherm, 24x11 inches, coming from a short wave diathermy with large 500 watt tubes is placed over the trunk of the patient to furnish the fever. I can best tell you of its efficiency by way of illustration.

One patient had had a swollen wrist, with excruciating pain for three weeks. He had scarcely slept during that time, requiring narcotics daily. He was put in the cabinet for ten hours. For eight hours his temperature was 104° or over, and for six hours of the ten it was 106° to 106.5°. His pain was so relieved that he slept like a baby that night. Two other treatments completely cured his wrist, except for some stiffness.

Two things should be emphasized. First, that unless the temperature is high enough you will not get results. And the second is that it is a treatment for a doctor to supervise. The pulse becomes very rapid, and the patient frequently needs supportive treatment.

Dr. Louis Orr, II, Orlando:

In view of Doctor Weiland's paper, I cannot let this opportunity pass to bring what is perhaps a word of cheer regarding recent advances in the use of hyperpyrexia in the treatment of gonorrhea and its complications. I do not believe the time far off when the experimental work now being done at the Miami Valley Hospital at Dayton, Ohio, and at the University of Rochester will have been completed and that hyperpyrexia machines will become available to all institutions of merit throughout the country. Up to the present date 55 Kettering machines have been released to various research centers throughout the country. The effort being made at the present time is to perfect both the machine and the technique of operation with the end in view of some degree of standardization of treatment with an elimination of the hazards associated with the treatment.

Warren, working at the University of Rochester, has been very successful in determining the thermal death points of the various strains of gonococci. Studies have been made on the organisms of each patient and the amount of heat necessary to destroy those particular bacteria is determined prior to the administration of hyperpyrexia. In this way the entire plan of treatment may be accurately determined and patients may oftentimes be spared unnecessarily long periods in the treatment machine.

It is quite interesting and oftentimes amazing to observe the great amount of benefit derived by patients with gonorrheal arthritis even after the first period of heat treatment. Hitherto acutely painful joints can oftentimes

be utilized with a fair degree of motion without severe pain and inflamed knee and ankle joints allow a considerable degree of weight bearing.

I feel that the day is not far off when hyperpyrexia administered by an expertly trained personnel, a requirement which is absolutely essential, will become available to all sufferers with gonorrhea and its distressing complications.

Dr. Arthur H. Weiland, Coral Gables (Concluding):

The statement was made that the hypertherm was most satisfactory in treating polyarticular gonorrheal arthritis. However, the rivanol treatment is just as applicable to cases with multiple joint involvement as to the monoarticular ones and the dangers and complications attending the use of the hypertherm are not present. Our treatment is easily carried out as an office procedure and again we wish to emphasize the gratifying results obtained in a large percentage of cases.

A SIMPLIFIED METHOD OF TREATING FRACTURES OF THE SHAFT OF THE HUMERUS*

CHAS. B. MABRY, M.D.,
Jacksonville.

It seems that we mortals are weak and fragile. When a twist or blow strikes us suddenly or unexpectedly our basic frame work may break and we become disabled. By accumulating knowledge we have learned to aid nature in repairing these breaks with various devices which reduce the overlapping and displaced bones and then hold them immobilized until healing and union occur. In the management of some fractures we have become very adept, in others we are still groping and searching for methods to improve the existing treatment which is giving poor results.

Fractures of the humeral shaft furnish a good example of our poor results. Because results in handling this fracture are notably bad there have been devised more methods for its treatment than for any other, more gadgets are used, more traction devices supplied, more postural attempts made and more extensive and more intensive casts applied. This can mean but one thing, and that is, our results are so poor that we are constantly trying some other method, some new method and hoping we will have better luck.

This paper will not deal with fractures of the head, surgical or anatomical necks of the humerus. Neither will it deal with fractures at or near the elbow joint since non-union in these locations is almost unknown. Union may occur in bad alignment, with malposition and with disabling rotations, but in these locations union always occurs. With fractures of the shaft the story is quite different. The text books tell us that non-union occurs most frequently in the humerus. Scudder says that following a simple closed fracture of the humerus in the middle third and upper third of the bone, non-union results more frequently than after fracture of any other bone. This happens even when the fragments are in good position. It occurs especially after a slight oblique or transverse fracture. After an infected compound fracture of the humerus, non-union is very likely to occur. Gravity through the weight of the forearm may keep the fragments of the fractured humerus apart and so favor non-union. Reports of orthopedic clinics throughout the world substantiate this. We are warned by them of the necessity of exact apposition and of complete immobilization, and are shown many and various appliances, gadgets and casts with which this may be best obtained.

Why is non-union in the humerus so frequent? There must be something wrong with our treatment. It is probably due in part to three factors: first, the almost impossibility of complete immobilization by any type of external apparatus; second, the difficulty of maintaining good approximation of the fragments; and third, necessity of preventing a space or distraction between them. It is the prevailing belief among orthopedists that constitutional factors such as diet, metabotic disturbances, syphilis and congenital anamolies have an insignificant part in these non-unions. Campbell believes that frequently in multiple fractures the demand for calcium is greater than the available supply and that this may account for some non-unions. But why should this be so in the humerus

*Read before the Sixty-fourth Annual Meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, 1937.

more than in other bones? Can it be that often there is some means of fixation used that greatly inhibits function in a limb that ordinarily has an extraordinarily great range of motion? I think the answer is, yes. Since man no longer uses the arm except in the pendant position, it seems only logical that fractures of the shaft during treatment should be held as is done in physiological use. Any other position is foreign to the normal. Huge aeroplane casts and splints, while immobilizing an entire arm, frequently fail to immobilize the humeral shaft. This is due to the marked flexibility of the shoulder, and is especially true when the cotton packs within the cast. As has been said, a frequent cause of non-union is distraction or separation of fragment ends during their period of immobilization. In my experience I have found it advisable to give special attention to traction apparatus like the Jones' arm type, in which distraction is very likely to occur.

The humerus requires but little traction for reduction. No bands of fascia limit the pull into position. The weight of the forearm in the pendant position will offer the proper amount of traction once the humerus is reduced. If there is a long spiral fracture with sharp ends and muscle interposition the best treatment is strong traction under a relaxing anesthesia. With sufficient traction the fragments will usually fall together. Should this fail, open operation may be necessary to approximate the fragments, but in my experience this has seldom been required. Operation, i.e., debridement, should be done in early compound fractures with suture of nerves and skin only. By early, we mean within the first eight hours after injury. If seen after eight hours the arm should be immobilized and the wound should be dakinized. Of course operation is necessary in total radical paralysis where function fails to return after a few weeks. I have had several such cases but that again is not within the range of this paper.

Since 1930 two of Jacksonville's hospitals have had 155 cases of fracture of the humeral shaft, not in the elbow or shoulder but in the shaft proper. Of these, 104 were in the Duval County Hospital and 51 in St. Vincent's Hospital in Jacksonille. Of this number, there were seven cases of non-union which required bone grafts.

Boehler of Vienna has recently reintroduced a treatment which I have used for the past two years in some exceptionally bad fractures. I have succeeded in getting union in every case. The essential features of the procedure are :—

The arm is placed along the patient's side



Figure 1



Figure 2



Figure 3

while the hand is grasped and strong pull made for a period of ten minutes by the clock. This is to reduce muscle spasms and permit reduction. It is advisable to have two assistants relay on this traction in order to avoid fatigue and to maintain constant force. At the end of ten minutes the operator manipulates the fragments into position while the assistant continues traction. The fracture having been reduced, the traction is moved to the condiles and the elbow is flexed to 90 degrees. The shoulder is wrapped in a circular fashion with five layers of 6-inch sheet wadding.

The arm is now ready for the plaster splint. The length of the splint is determined by taking a piece of roller bandage, putting one end in the axilla then unrolling it over the flexed elbow and ascending the lateral side of the arm to the shoulder at the level of the acromial process. This measured length is now laid out on a flat board or table. For the next step a 6-inch plaster bandage is immersed in water until all bubbling ceases. The plaster bandage is then grasped by both ends and removed from the bucket and the ends are slightly squeezed together. The splint is made by unrolling the wet bandage on the flat board the desired length, then reversing to the point of starting and repeating this process until the splint is 8 layers of plaster thick. The splint is now lifted from the board (Fig. 1). One end is held in the axilla, while the splint descends the internal border of the humerus, rounds the elbow and travels up the outer side of the humerus to the shoulder (Fig. 2). The splint must be wet and soppy and have no wrinkles which might form on the skin and cause pressure ridges. The posterior part of the splint at the elbow is flapped to one side and molded to the bony prominences. The plaster is now encircled by 3 inch gauze bandages which are neither tight nor loose and the splint is complete (Fig. 3). Following this a muslin sling supports the hand only. It must not support the arm as the weight of the arm maintains the proper amount of traction during healing.

The after-care is equally simple. The patient is ambulatory with his arm in a sling. Occasionally a posterior angulation occurs in the distal fragment which is easily corrected by elevating the wrist nearer the opposite



Figure 4. Early fracture of humerus



Figure 5. Five weeks later. Note abundant callus

shoulder. We have had no difficulty in doing this. The patient is instructed from the first to exercise his grip by squeezing a rubber sponge, hundreds of times a day. This accelerates circulation and promotes function.

CONCLUSIONS

1. The arm is treated in its anatomical position.
2. Adequate immobilization is accomplished by the use of unpadded plaster splints.
3. Excessive traction, the frequent cause of non-union, is avoided.
4. Function is maintained throughout the treatment.
5. Callus is abundant in this method in contrast to its scarcity in other methods.
6. By muscle function with bone immobilization the healing process is hastened and the convalescence shortened.

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DISCUSSION

Dr. J. S. Turberville, Century:

I don't think we should let this paper go by without discussion. I was impressed with what the doctor had to say about functional results. That is the important thing after all. I noticed that he got one in all of his cases. I think that we have given too much attention to perfect anatomic restoration of breaks and placed too little attention on functional results. That is brought about a good

deal by the use of the x-ray. Some of us practiced many years before we had the x-ray and we got some pretty good arms for people to use. After getting the x-ray we had trouble with breaks because we did too much manipulation in our efforts to obtain perfect anatomical results. If you can get fractures in alignment and not much shortening, I think you had better be satisfied and not spend too much time in restoring the anatomical outline.

I enjoyed the doctor's paper very much and I was very much impressed with his pictures.

Dr. Chas. B. Mabry (Concluding):

I wish to thank Doctor Turberville for his discussion. We have used this method of treating fractures of the humerus for the past two years on approximately 40 cases. Our results have been uniformly satisfactory and we have not had a single case of non-union. I have been surprised how quickly callus is formed around these fractures and how soon union occurs. Our patients are allowed out of bed and consequently have a more cheerful frame of mind. They are started off with exercises of the hand and forearm by gripping a rubber sponge. They rarely complain of pain after the first two days, and they say that they never feel the bones move against each other.

The compound fractures are slightly slower in uniting. We had two extremely bad compound fractures which were treated by this method of immobilization after initial dakonizing. The wounds drained moderately and rapid union occurred. In one case an entire arm was almost severed. Debridement was done and the radial nerve sutured but the wound broke down. In spite of this, good union occurred and the radial nerve was later resutured. My results in the past two years have been so satisfactory with this method of treatment that I would hesitate to return to the old.

PRACTICAL APPLICATIONS OF VITAMIN D*

J. Sudler Hood, M. D.
Clearwater

In the medical literature there is no more interesting chapter than that of the advances made in the study of calcium and phosphorus metabolism. When one finishes reviewing the literature there are many questions which remain unanswered, questions of the utmost importance to an understanding of the physiology and pathological conditions of our bodies, questions which challenge the medical profession to continued investigation.

The calcium and phosphorus metabolism when altered gives rise to many pathological conditions. These substances in their ramifications involve almost every part of the body. To emphasize the importance of these substances, let your mind run hastily over the pathological conditions which they influence: arteriosclerosis, arthritis, osteomalacia, osteitis fibrosa cystica, rickets, dental caries, tetany and many others.

The physiology of the parathyroid gland and vitamin D are intimately associated with the utilization of calcium and phosphorus. The short time at our disposal tonight allows us to review only a few of the studies and facts we have learned about vitamin D.

Vitamin D is fat soluble and is found in the unsaponifiable or sterol portion of certain oils. Nearly all fish oils contain it. The fish liver oils are the most potent. Bills[1] has made an extensive study of the concentrations of vitamin D in various fish and found that there was a great difference. Bluefin tuna liver oil stood first with 40,000 International or U.S.P. units per gram; swordfish liver 10,000; black sea bass liver 5,000; chinook salmon liver 1,300; halibut liver 1,200; cod liver 100; haddock liver 10. As liver oils go the cod's liver is only 1/400 as potent as that of the bluefin tuna. The popular impression that milk, butter and leafy vegetables are practical sources of vitamin D is quite false. This notion arises from the early confusion of vitamin D with vitamin A. These two vitamins were clearly separated by McCollum and his coworkers[2] in 1922, and should no longer be confused. Butter, milk and leafy vegetables are poor sources of vitamin D.

The most striking demonstration of the influence of vitamin D is its ability to prevent rickets in infancy. Individuals and experimental animals can be protected against rickets by direct irradiation, ingestion of irradiated substances containing the provitamin, or ingestion of fish oils naturally endowed with

*Read before the Pinellas County Medical Society, May 21, 1937.

vitamin D. Much of the recent work has been devoted to comparing the efficiency of these different substances in preventing or curing rickets. The most important substances under investigation are irradiated milk, "yeast milk", fish liver oils, irradiated ergosterol, crystalline vitamin D or calciferol, and irradiated cholesterol. Evidence is accumulating which indicates that irradiated ergosterol is not the active substance or, at least, not the only active form of vitamin D in all of these products.

It is likely that direct irradiation of the body of the subject with ultraviolet rays activates the provitamin of cholesterol in the skin which, in turn, is absorbed and protects the individual against rickets. That some substance in the skin is responsible was clearly shown by Hess and Weinstock.[3] They took sections of excised human skin, some of which they irradiated, while other pieces were untreated and used as controls. The skin was then fed to rats and that which had been irradiated protected the rats against rickets, while the untreated gave no protection. In other words, irradiation of human skin induced specific properties in it, which prevented the development of rickets, even though the skin was deprived entirely of nerve and blood supply.

The rays that are responsible for the alteration in ergosterol and cholesterol are found in the ultraviolet region of the spectrum. These have been isolated by the use of artifical light which has been passed through various filters. To quote Park:[4] "Hess and Anderson found that wave lengths of 310 and 313 mu. are slightly effective, and Sonne and Rekling that wave lengths of about 300 are very effective, those around 280 effective, and those around 260 mu. valueless. Window glass which removes ultraviolet rays shorter than 315 mu. deprives light of all its antirachitic power. The ultraviolet radiations active in rickets, then lie between 315 and 260 mu. corresponding in their range to the absorption spectrum of ergosterol."

In Florida where everyone is climate conscious it might be of interest to study the mechanism by which the ultraviolet rays reach the earth. Again quoting from Park:[4] "The solar radiations shorter than 200 mu. convert the oxygen of the air into ozone, while those between 200 and 300 mu. change the ozone back into oxygen. Through the action of the short ultraviolet radiations of the sun, a blanket of ozone, in continual process of formation and dissolution is maintained in the outer layers of the atmosphere. This blanket acts as a great screen which is totally impermeable to radiations shorter than 290 mu. and through its exclusion of them makes life on the earth possible. To the antirachitic radiations between 290 and 315 mu. the blanket is only partially permeable, removing as one might expect, the shorter more effectively than the longer."

Where sunshine is such a constant blessing as in this locality rickets should be a rare finding. Hess[3] was surprised to find, while making a trip to Central America, that many of the children showed evidence of mild rickets. Eliot[5], on the other hand, found it very rare among the infants of Puerto Rico. In Florida rickets should be uncommon if the infants while young are exposed to the ultraviolet rays of the sun.

It was largely through the investigation of irradiated cholesterol that the early advances in irradiation and its connections with vitamin D were made. With the discovery of the high potency of irradiated ergosterol, and because of the great similarity of ergosterol chemically and spectroscopically to the provitamin D of cholesterol, they were generally accepted as being identical. The exact chemical formula of vitamin D is not yet known. Ergosterol itself is not antirachitic but after it is irradiated it acquires this ability. Irradiation does not alter the structure of ergosterol except in the arrangement of the molecules. The chemical constituents remain the same and the energy derived by ignition in a combustion chamber is the same; so that it has been concluded that ergosterol and irradiated ergosterol or viosterol are isomeric. Ergosterol has 28 carbon groups in its chemical formula while cholesterol has one less or 27. But both will prevent and cure rickets after they have been treated with ultraviolet rays. At the present time according to Bills[6] there are eight different forms of vitamin D artificially prepared which will prevent rickets. Two forms are present in fish oils which may or may not be identical with two of the artificially prepared forms. There are probably many more.

Let us turn our attention to the various

products on the market which contain vitamin D and how they can be used clinically. The standard accepted by the League of Nations in 1931 and the United States in 1934 is the International or U.S.P. unit. One gram of good cod liver oil contains 100 International units. Actually the various antirachitic substances are standardized by their ability to cure rickets in rats under certain standardized conditions, which must be strictly adhered to in regard to diet, size and weight gain of the rats, and light present in the rooms in which the animals are caged. The biological method of standardization is most sensitive and based on the investigation of Shipley, Park, McCollum, Simonds and Parsons[7]. Bills[8] states that, "A rickety rat will respond to less than 1 part per billion of vitamin D in its diet, . . . For comparison, it may be mentioned that the the animal test for vitamin D is approximately 1000 times more sensitive than the delicate spectrographic test for ergosterol." Products that are not well standardized are of little value.

Vitamin D is extolled by every detail man who sets foot in a doctor's office. The advertising material which constantly confronts the public and the physician points the way to a panacea little short of eternal bliss. With these claims in mind, it is wise to critically investigate the products on the market today.

Cod liver oil has long been recognized as the standard in prophylactic and curative treatment of rickets. One teaspoonful or one dram three times a day furnishes 1200 I.U. This is adequate to protect the average infant against rickets, but in this dosage will not cure all active cases.

Viosterol or irradiated ergosterol in corn oil has been given to infants in varying quantities. Five drops is equivalent to 1150 I.U. and gives protection to most infants. Shelling and Hopper[9] had only one case develop in 175 infants treated with this dosage. Eliot and coworkers[10] had 9 out of 50 cases treated with 1361 to 1392 I.U. Drake, Tisdale, and Brown[11] in a group of children under 4 months of age at the beginning of medication, found 6 patients out of 27 who received 1080 I.U. showed rickets. Ten drops daily is more satisfactory, though the increase in dosage is not followed by as striking results as one would anticipate.

Irradiated milk, both evaporated and fresh milk, have been fed to infants with such favorable results that almost all evaporated milk is now irradiated. The commercial products, however, do not contain enough vitamin D to protect the baby completely while small. The infant does not have large enough intake of the formula to supply adequate amounts of vitamin D without some other source. As he grows and drinks more milk, the requirements are approached.

Crystalline vitamin D has been investigated by Lewis[12]. He placed it in oil, propylene glycol, and in propylene glycol and milk. At the dosage levels, 290 and 1450, he found it gave good protection and was most effective when placed in milk after it had been dissolved in propylene glycol.

Other investigators have also found that the antirachitic substance is more effective when given in milk as the menstruum. Viosterol, vitamin D concentrates, and cod liver oil seem to give better results when thoroughly mixed with milk. By this I mean a true emulsion; or the antirachitic and milk should be homogenized together. The practice of dumping a teaspoonful of cod liver oil in milk or orange juice and stirring it around is to be discouraged. The oil sticks to the glass and much is lost.

There are numerous vitamin D concentrates as well as mixtures of potent oils on the market. These can be given in drops just as viosterol. The ease of administration is their greatest advantage. Some investigators think the products from these natural sources are more beneficial than viosterol, but the question is not yet settled.

What is the danger of giving an overdose and how toxic is vitamin D? To quote from Bills:[1] "The lethal dose of vitamin D for man is unknown. The range between its ordinary therapeutic dose and the dose which produces adverse symptoms is extraordinarily wide, wider perhaps than is the case with any other potent drug . . . . . Hess, Poncher, Dale and Klein[13] administered as much as 40 times the ordinary dose of irradiated ergosterol to babies for 6 months, and noted no untoward effect other than a tendency to constipation and colic. Almost the largest doses ever given were those administered by Rappaport and Reed[14], and Reed[15] to patients with hay fever and other ailments. At the maximum, the dose amounted to 3 cc. daily of a

concentrated irradiated ergosterol solution. . . known to contain 1,000,000 I.U. of vitamin D per gram of oil." (This dose would be equivalent to 30 liters of cod liver oil daily.) "Such an enormous dose was more than some individuals could tolerate with comfort, yet it produced no serious poisoning."

The diseases which are aided by vitamin D therapy are varied. First and foremost is infantile rickets, both the low calcium and low phosphorus varieties. Next is infantile tetany, caused by low blood calcium. Here a note of warning is in order. Supply the needed calcium and then give vitamin D. If vitamin D is administered in large amounts to a child with a low blood calcium the tendency is to bring about deposition of calcium in the bones thus further lowering the blood calcium and producing profound tetany.

Lead poisoning can be benefited in the acute stage by the administration of calcium, phosphorus and vitamin D. The purpose of this treatment is to reduced the amount of lead in the circulating blood and depositing it in the bones. Lead combines with phosphorus to form lead phosphate and vitamin D encourages its incorporation in the bony structure. Too much calcium will defeat this purpose as it likewise combines with the phosphate. If calcium is present in excess it will supplant the lead.

In pregnancy and during the period of lactation, vitamin D is also beneficial. According to Hamilton[16] 85% of the body calcium is deposited in the fetal skeleton during the last 3 months of pregnancy. This is a severe strain on the maternal supply, and if adequate provision is not made in the diet the maternal tissues will suffer. Lactation places a similar demand on the nursing mother.

The premature infant deserves special mention. The investigation of Davidson and Merritt[17] emphasizes the importance of starting vitamin D administration at the time of birth. The premature infant is confined indoors so that the sunlight cannot aid in supplying ultraviolet rays. Vitamin D administration must be provided or rickets is almost sure to develop. It is advisable to give between 2,000 and 3,000 I.U. daily.

Vitamin D has been recommended in tuberculosis because it accelerates calcium deposition in the tubercle. It is particularly helpful in tuberculosis of the bone. Some patients with general lassitude and inanition improve under this therapy; just why it is hard to say.

Much has been learned about this vitamin as well as the roles played by calcium and phosphorus in the body, but much remains unknown and challenges us to greater endeavor in the future.

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TREATMENT OF FRACTURES*

(Recent Changes in the Use of Piano Wire and Steel Pins)

Prescott LeBreton, M. D.
St. Petersburg

The advent of Steinmann pins and piano wire has brought about in the last few years marked changes in the treatment of fractures. As the use of these pieces of hardware has grown familiar, different combinations of treatment have suggested themselves. Many fractures formerly handled by traction in bed, with prolonged hospitalization, are now made ambulatory. Also many automobile cases, marked by comminution of bone or multiple breaks, or by bizarre deformity, can be better handled by a judicious combination of pins, or wire, or both, incorporated in a plaster cast. The metallic ready-made splints, hanging in the wardrobe of the hospital, are used less and less, as they do not meet the indications.

The fear of infection from the introduction of pin or wire through the bones, has grown less as we so seldom see it. Nature throws out a protecting wall of granulations about the metal, which closes down rapidly after its withdrawal. Less often is the open operation done on closed fractures, as one becomes accustomed to the accurate skeletal pull of a pin and sees the results with the aid of the fluoroscope. After the cast is on, incorporating the pin or pins, one can await with confidence the x-ray checkup on position.

Boehler has emphasized the value of firm fixation and early function. Skeletal fixation gives the firm splinting, and allows early motion and partial function for the extremity. Gaenslen, in his Robert Jones lecture in New York on fracture of the hip, believes that the bony union and good function after the nailing of fractured hip are due to the firm fixation and constant function. In other words the plaster cast, no matter how closely applied, allows motion and strain at the site of the fractured hip, and this motion is the cause of the bad results often seen. The practise of allowing some weight-bearing on a walking cast or of keeping a hand at work while a remote fracture is rigidly splinted, means good circulation, lack of atrophy, lack of stiffness, and a return of early function.

In reviewing his fracture cases of the last four years, the writer found that he had used pins or wire in seventeen per cent of his cases, an average of one in six. The following points seem to be of value and of practical use:—

1. In preparing to use skeletal traction on a case, it is best to have ready several pins or wire of different sizes and lengths; also strong forceps for withdrawal in case of faulty introduction; also a good assistant who can watch from another vantage point that the pin is placed transversely and squarely instead of being placed at a bad angle.
2. Cheap pins, without chrome finish, made from motor cycle spokes, are very satisfactory and also are good for spiking hips in three and three and one-half inch lengths.
3. Four piano wires, cut off close to the bone, will hold an onlay bone graft over a nonunion with great firmness and can be left in situ indefinitely.
4. After doing an osteotomy to correct a vicious angle in a bone, a wire may be introduced to hold the position until union in good alignment has occurred.
5. "Bumper" fractures below the knee, where a triangular fragment is out of position, can be held after open operation, very nicely, by metal.
6. "Nailing" of a fractured hip is a two hour job, but saves greatly in after care and expense. The patient does not appreciate the fredom from cast wearing or the lack of knee stiffness which beset the case treated by a long spica. If one has not seen cases that have been nailed, to compare with cases treated by other means, he would be surprised to witness the comfort and ease of a nailed case. It is quite amazing to see how the majority of patients can move about and sit up.
7. Of great assistance are the Hoke traction apparatus, the Roger Anderson splint, or the mechanical apparatus now sold by various firms.

American Legion Hospital.

*Read before the Annual Meeting of the Florida Midland Medical Society, Plant City, Oct. 27, 1936.

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FLORIDA MEDICAL DIRECTORY

The publication of a Medical Directory for doctors licensed to practice medicine in Florida was approved by the Executive Committee at its last meeting, held just prior to the Pre-convention Meeting in Tampa, the middle of January. The State Board of Health, at its annual meeting held in Jacksonville, February 8, unanimously endorsed the Directory. The Secretary of the State Board of Medical Examiners, in a recent communication, stated: "Relative to my reaction on the proposed Medical Directory for Florida, I think it is the best thing the Association has ever done and indicates a spirit to give the members something for their money." With the full cooperation of the Medical Association, the State Board of Medical Examiners and the State Board of Health, this Medical Directory should be a definite success.

The price of the first edition of the Directory is $1.00 a copy. A complimentary copy will be mailed to each member of the Florida Medical Association. Each additional copy will be $1.00. Every effort will be made to have this new Medical Directory for Florida in the mail before the annual convention in Miami next May.

The first section will contain the names and addresses of the members of the Florida Medical Association, by component societies; the second section, the names of doctors licensed to practice medicine in Florida, by cities; the third section, an alphabetical list of doctors licensed to practice in the state. Throughout the Directory, the names of doctors who are affiliated with organized medicine will be shown in capital letters. The names of doctors who are licensed to practice in the state, but are not members, will be shown not capitalized. A symbol after the doctor's name will indicate that he has recorded his license with the Clerk of the Circuit Court and registered with the State Board of Health.

For many years the Association's membership roster has been shown in the February Journal. This practice has been discontinued, since the complete roster will be shown in the new Medical Directory.

The officers of the Association hope this Florida Medical Directory will be a valuable service to the medical profession.

NATIONAL DEPARTMENT OF HEALTH

"The federal government expends between one and two hundred million dollars annually for the conservation and promotion of health, exclusive of the money expended for those purposes in the army and navy. Through the federal subsidy system it supervises and directs the expenditure of many millions of state money for health purposes. The magnitude of the expenditure, even when regarded simply as a business proposition, calls for the organization of a national Department of Health. The social, economic and military value to the country of the health and lives of its 125,000,000 inhabitants makes the creation of such a department imperative."

This comment is reproduced from the January 22, 1938 A. M. A. Journal. Beginning with page 25B of that issue will be found a study by the Bureau of Legal Medicine and Legislation, covering several pages, under the caption, "Why a United States Department of Health."

"It [the analysis] defines an executive department, tells why a unified Department of Health can render more efficient service for the

health of the people than can many minor units, and explains the weakness of the plan now before Congress for the creation, not of a Department of Health, but of a Department of Welfare. The interests and loyalties of the secretary at the head of a welfare department must necessarily, by reason of his education, training and experience, be biased in favor of educational activities or of welfare activities or else divided among the three fields with which the department is concerned. Every reader of The Journal who is interested in public affairs should read this article. Then, if you are convinced that a national Department of Health should be established, write to your Senators and your Representative expressing your views. The Board of Trustees of the American Medical Association and the House of Delegates of the Association have already expressed their approval of this movement."

ANNOUNCEMENT—MEDICAL SHORT COURSE

At the Pre-Convention Meeting held in Tampa, Sunday, January 16, 1938, among other reports made was that of the Committee on Medical Postgraduate Course. Through its chairman, the committee made a report carrying with it some interesting observations. The graduate short course has been held for five years. The first year a guarantee of $500.00 was made by the Florida Medical Association. Because of the success of the first course, an appropriation of $500.00 was made the second year. At the time of the report but $132.92 of that original $500.00 had been used. The attendance in 1937 was 136. This means that the per capita cost was very slightly over 50c.

An analysis was also made of the attendance which indicates that for the five years a few men have attended every session but that over the five years approximately half the membership of the Florida Medical Association has attended one or more sessions.

Men interested in special fields of work and practicing in the larger medical centers are attending in increasingly large numbers.

It was announced that the next short course will be held either in Orlando or in Daytona Beach, June 27 to July 2, inclusive. The schedule will be similar to that of last year.

FINANCIAL STATEMENT OF COMMITTEE ON MEDICAL POSTGRADUATE COURSE
JANUARY 1 TO DECEMBER 31, 1937

Balance in Bank, January 1, 1937	$438.51	
RECEIPTS		
Registration: 136 at $5.00	680.00	
		$1118.51
Bills Paid		
Stamps, telephone calls, telegrams	$ 41.50	
Stenographic services	125.25	
Respess Engraving Company (cuts for Journal)	9.66	
Colonial Orange Court Hotel (hotel expense, speakers)	110.54	
Pepper Printing Company (printing)	12.50	
Harry Taylor (signs)	38.00	
Dr. W. L. Bierring (expense account)	152.40	
Dr. W. E. Burnett (expense account)	112.42	
Florida Tuberculosis and Health Association (Transportation: Jacksonvillle to Orlando and return, Dr. Pol N. Coryllos)	23.40	
Dr. Bayard Carter (expense account)	65.15	
Dr. C. C. Coleman (expense account)	47.30	
Dr. Ralph Greene (materials, drawings, etc.)	11.00	
Bank tax	2.30	
Total		$ 751.42
Balance		$ 367.09

T. Z. CASON, M. D., *Chairman*,
Medical Association Graduate Course, Inc.

INTERNATIONAL COLLEGE OF SURGEONS

Sectional Meeting:
Florida, Georgia, Alabama, Louisiana, and Mississippi.
Tampa Municipal Hospital
Tampa, February 28, 1938
9 A.M.
Members of the Florida Medical Association are invited

PROGRAM

Andre Crotti, M.D. ..... Columbus, Ohio
"Some of the Newer Aspects of Endocrines"
Max Thorek, M.D. ..... Chicago, Ill.
"Electrosurgical Obliteration of the Gallbladder." (Lantern slides and motion pictures)
Charles H. Arnold, M.D. ..... Lincoln, Neb.
"Splanchnic Anesthesia"
Edgar F. Fincher, M.D. ..... Atlanta, Ga.
"Chronic Sciatica Resulting from Displacement of the Intervertebral Cartilage"
Oscar B. Nugent, M.D. ..... Chicago, Ill.
"Surgical Management of Cataract"
Gilbert Franklin Douglas, M.D. ..... Birmingham, Ala.
"Study of Uterine Bleeders, Endometrial Biopsies." (With lantern slides)
Hugh Young, M.D. ..... Baltimore, Md.
Subject to be announced
George Van Ingen Brown, M.D. ..... Milwaukee, Wis.
"Plastic Surgery"

Chevalier Jackson, M.D. ..... Philadelphia, Pa.
Subject to be announced
Edward Frankel, Jr., M.D. ..... New York City
Subject to be announced
Moses Behrend, M.D. ..... Philadelphia, Pa.
Subject to be announced
William Jepson, M.D. ..... Sioux City, Iowa
"The Future of Surgery and How We May Improve It"

Luncheon will be served by the Tampa Municipal Hospital for all visiting doctors.

Further information may be secured from Julien C. Pate, M.D., 1101-5 First National Bank Bldg., Tampa.

PRE-CONVENTION HIGH LIGHTS

The Pre-Convention Meeting of the State Association was held in Tampa at the Hillsborough Hotel, Sunday, January 16, 1938. The forenoon was devoted to committee meetings and at 12:30 a luncheon was served for all present. At the close of the luncheon, President Edward Jelks called the meeting to order. The following named past presidents who were present were recognized:

Dr. F. Clifton Moor, Tallahassee
Dr. John C. Vinson, Tampa
Dr. John S. McEwan, Orlando
Dr. H. Mason Smith, Tampa
Dr. Julius C. Davis, Quincy
Dr. Gerry R. Holden, Jacksonville
Dr. William M. Rowlett, Tampa
Dr. Herbert L. Bryans, Pensacola
Dr. O. O. Feaster, St. Petersburg.

Doctor Jelks then recognized the following officers of the Association who were present: Dr. W. Henry Spiers, President-elect; Dr. George L. Cook, Third Vice-President; Dr. Shaler Richardson, Secretary-Treasurer and Editor of the Journal; and Stewart Thompson, Managing Director.

The gavel was turned over to Dr. W. McL. Shaw, Chairman of the Council, who gave a brief outline of the activities of the Council so far this year. He also stated that the councilors have been more active this year than for any other year in the history of the organization, as far as he knew. Doctor Shaw particularly emphasized the importance and success of the six annual medical district meetings which were held during the year. He also reported on a meeting of the Council which was held just prior to the luncheon and advised that the Council had set a schedule of meeting dates and places for 1938 for the medical districts. The Council authorized the following designation of titles: the senior councilor may be known as the president and the junior councilor as the president-elect of the medical district, with the understanding that the status of councilor shall not be altered.

Doctor Shaw then called for the reading of the councilors' reports. Dr. John S. Turberville, Councilor, District A-1, was unable to be present but mailed his report which was read by the Chairman. Dr. N. A. Baltzell, Councilor, District A-2, also was not present but his report was received and read. Dr. A. B. Albritton, Councilor, District B-4, was not present but his report was received and read. Dr. J. W. Alsobrook, Councilor, District D-7, made an oral report and will mail his written report later for publication. Dr. F. K. Herpel, Councilor, District F-11, read his report. Dr. H. A. Walker, Councilor, District F-12, read his report. These councilors' reports appear in the Journal and a general report for the Council will be made by the Chairman, Dr. W. McL. Shaw, at the annual meeting in Miami. The Chairman complimented the councilors very highly on their work during the year and expressed deep appreciation for the splendid cooperation.

The gavel was then turned back to President Edward Jelks who recognized the chairmen of various committees. Dr. Gilbert S. Osincup, Chairman of the Executive Committee, was recognized and made a brief report on the meetings of the Executive Committee held so far this year. One important change in the schedule of the program for the annual meeting in Miami was the designation of the time for the first meeting of the House of Delegates. The time was officially set at 9 a. m. on Monday. Doctor Osincup emphasized the fact that an increase in committee reports and problems presented at the House of Delegates made necessary more time for deliberation. This new schedule will give the first meeting of the House of Delegates from 9 a. m. Monday until noon, which the committee feels will be very important in the life of organized medicine.

Dr. Leigh F. Robinson, Chairman of the Committee on Scientific Work, was recognized. Doctor Robinson reported that his committee met during the forenoon and completed the scientific program for the Miami

meeting. Fifteen very excellent papers were accepted, after due consideration had been given to subject matter and the geographical location of essayists. He lamented the fact that, owing to the lack of time for presentation of scientific papers, it was not possible for his committee to assign places on the program to some other very worthy papers. Just previous to the luncheon, the committee had forwarded a telegram to Dr. L. M. Anderson of Lake City, a member of the committee who was not able to attend the meeting.

Dr. Leland F. Carlton, Chairman of the Committee on Medical Education and Hospitals, was recognized and made a brief report. On behalf of his committee, Doctor Carlton requested the opinion of those present concerning a survey of hospitals which is to be made by the WPA. The action of those present was understood to be unofficial and simply in an advisory capacity. Doctor Carlton was advised that those present recommended that the survey be sponsored by the State Board of Health in conjunction with the Association's Committee on Medical Education and Hospitals and that the results obtained be transmitted to our representatives in Washington with an honest interpretation of the findings.

Dr. J. Ralston Wells, Chairman of the Public Relations Committee, was then recognized and made a brief report on his committee's activities, in connection with broadcasting over station WRUF.

Dr. Calvin D. Christ, Chairman of the Committee on Necrology, made a brief report, giving the names of the deceased doctors this year.

Dr. T. Z. Cason, Chairman of the Committee on Medical Postgraduate Course, was recognized and made a preliminary report on this year's postgraduate course which will be held a little later than in previous years, in order not to conflict with the A. M. A. meeting in San Francisco. A full announcement regarding this postgraduate course will be published in The Journal as soon as it is available and will also be mailed to the individual doctors.

Dr. F. Clifton Moor, Chairman of the Cancer Control Committee, was then recognized and made a brief report on his committee's activities.

Dr. William M. Rowlett, Chairman of the Inter-Relationship Committee, was recognized. He reviewed the medical legislation and emphasized the importance of cooperation by the State Board of Health in the utilization of two field workers who have been used in making investigations of "irregulars."

Dr. H. Mason Smith, Chairman of the Committee on State Controlled Medical Institutions, was recognized and reported briefly.

Dr. Herbert L. Bryans, the Association's delegate to the A. M. A., was recognized and made a brief oral report as a preliminary to a more complete report which will be given at the meeting in Miami.

By standing vote, those present expressed their appreciation to the Hillsborough County Medical Society for the splendid entertainment during the Pre-Convention meeting and in particular to Dr. John C. Vinson and Dr. George L. Cook of the local committee on arrangements. The total registration at this meeting was 47. Their names follow:

Alsobrook, John W.	Plant City
Andrews, C. A.	Tampa
Andrews, Mitchell M.	Orlando
Blackmon, H. J.	Tampa
Blake, W. C.	Tampa
Bryans, Herbert L.	Pensacola
Carlton, Leland F.	Tampa
Cason, Turner Z.	Jacksonville
Cook, George L.	Tampa
Cowart, James T.	Tampa
Davis, Julius C.	Quincy
Davis, W. M.	St. Petersburg
Dickinson, J. C.	Tampa
Duke, R. R.	Tampa
Estes, J. L.	Tampa
Feaster, O. O.	St. Petersburg
Ferguson, R. D.	Ocala
Gilmer, Eugene S.	Tampa
Gray, Frank D.	Orlando
Helms, John S., Jr.	Tampa
Herpel, F. K.	West Palm Beach
Holden, Gerry R.	Jacksonville
Jelks, Edward	Jacksonville
Johnston, Hewitt	Orlando
Knowlton, R. H.	St. Petersburg
Limbaugh, Louie	Jacksonville
Lowry, Blackburn W.	Tampa
McEwan, John S.	Orlando
Mallory, Meredith	Orlando
Moor, F. Clifton	Tallahassee
Orr, Louis M. II	Orlando
Osincup, Gilbert S.	Orlando
Pate, Julien C.	Tampa
Richardson, Shaler	Jacksonville
Robinson, Leigh F.	Ft. Lauderdale
Rowlett, W. M.	Tampa
Shaw, W. McL.	Jacksonville
Smith, H. Mason	Tampa
Spiers, W. Henry	Orlando
Taylor, Joseph W.	Tampa
Thomas, W. C.	Gainesville
Thompson, Stewart	Jacksonville
Tillman, George C.	Gainesville
Vinson, J. C.	Tampa
Walker, Harrison A.	Miami Beach
Webb, Carol C.	Pensacola
Wells, J. Ralston	Daytona Beach

REPORTS OF DISTRICT COUNCILORS*

FIRST DISTRICT—

J. S. Turberville, M.D.....*Century*
Bay, Escambia, Holmes, Okaloosa, Santa Rosa, Walton, Washington.

As it will be impossible for me to be at the Pre-Convention meeting I am, herewith, submitting my report of action of the past year.

You are already familiar with the sectional meeting we had at Apalachicola last August. The societies of the district have had about a normal activity during the past year except Escambia county. This county in cooperation with clinic organizations is purchasing an iron lung; has organized a staff of a maternity hospital for indigent patients; entertained Dr. Morris Fishbein; and participated in the formation of a combination lay and professional board of health which supervises the welfare department, county physicians' department, and the health department.

SECOND DISTRICT—

N. A. Baltzell, M.D.....*Marianna*
Jackson, Calhoun, Gulf, Gadsden, Liberty, Franklin, Leon, Wakulla, Jefferson.

The second councilor district comprises the counties of Jackson, Calhoun, Gulf, Franklin, Gadsden, Leon, Liberty, Wakulla, and Jefferson.

Jackson county's medical society had a paid-up membership of 13 for 1937. Meetings which are held on the second Tuesday each month are fairly well attended. With the addition recently of several young doctors in this society an apparent new and increased interest is manifest.

Gulf county with only two physicians and their locations some distance apart, is not affiliated with any county society. However, since one of these towns has recently become a considerable industrial center it is quite possible in the near future that the acquisition of more doctors will bring about a keener interest in medical organization.

The Banner Society in District No. 2 is the District Two Medical Society, comprising the counties of Leon, Gadsden, Liberty, Waukulla and Jefferson. This society has 35 members paid up for 1937. There are held four meetings each year; each meeting has at least one outside guest speaker and the society has from five to six scientific papers read and discussed at each meeting. Always guests from neighboring towns are present, especially from Marianna, Fla., Thomasville, and Bainbridge, Ga.

Franklin county has no medical society, but one or more of its physicians can be seen occasionally attending the meetings of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society.

On the whole, organized medicine in the Second District seems to have acquired a keener interest and enthusiasm in the past year than heretofore, doubtless enhanced by the meeting of the Northwest District A assembly in Apalachicola last summer.

THIRD DISTRICT—

R. B. Harkness, M. D.....*Lake City*
Baker, Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor.

The following observations are offered by your councilor from the third district. The members of the medical profession in this district have shown a healthy interest in matters pertaining to organized medicine. Such interest has been stimulated through the efforts of our President and Chairman of the Council, in changing councilor districts and holding meetings in each district. This has brought the rank and file of medical men into closer touch with the state organization and its officers. These meetings have been well attended. Interest of the men in the third district is further stimulated by membership in the Suwannee River Medical Association, which meets monthly.

Notwithstanding the efforts that have been made in the interest of organized medicine, we still have quite a number of good men who are not members of the state association. To each of such, your councilor has mailed a personal appeal for more general support of our state organization.

Your councilor is of the belief that more general support of our state organization would be secured if membership in it carried some tangible benefit in the nature of disability insurance. To this end, he recommends that our committee on Medical Economics, or a special committee, study this matter with the idea of offering to our state Association, some plan of disability insurance. He believes that even should such a plan necessitate increased dues, the results would be worthwhile.

*Read before the Pre-Convention meeting, Tampa, January 16, 1938.

FOURTH DISTRICT—

A. B. Albritton, M. D. ..... *Wildwood*
Alachua, Bradford, Citrus, Gilchrist, Hernando, Levy, Marion, Pasco, Sumter, Union.

There are ten counties in the Fourth Councilor District. There are four county medical societies within the boundaries of District Four, with a total membership of 65 for 1937. Their members and the percentage of dues paid are as follows:

	Members	Paid
Alachua	25	92%
Marion	22	100%
Pasco-Hernando-Citrus	13	100%
Sumter	5	100%

During the year two new members were accepted into the Alachua County Medical Society and two old members were lost; Dr. Fred Mathers moved to Orlando and Dr. John D. Raborn died on July 21, 1937. One new member was accepted into the Marion County Society. Two new members were taken into the Pasco-Hernando-Citrus County Society. Two members were lost to this society by removal; Dr. John J. Bourke to Albany, New York; and Dr. Leland H. Dame to West Palm Beach. Dr. A. B. Cannon died on May 25, 1937. Two new members were accepted into the Sumter County Society. One member was lost by death, Dr. Samuel C. Wood.

There are fifteen doctors in Councilor District Four who are not now members of the State Association but who were former members. Considerable work has been done among these former members in an effort to influence them to become reinstated. We hope the work that has been done may be an aid, during the coming year, to bring these members back into organized medicine.

Our Councilor District, Number Four, joined with Councilor District Three for an annual meeting in the North Central Medical District (B). This meeting was held at Ocala, Wednesday, October 27. A complete writeup on this meeting will be found in the December, 1937, Medical Journal, page 345.

ELEVENTH DISTRICT—

Frederick K. Herpel, M.D. ..... *West Palm Beach*
Palm Beach, Broward.

I have the following report to make of my activities as councilor for the Eleventh District for the year 1937:—

There are no matters of general interest to report from Palm Beach County during the past year. Increasing interest has been manifested in the county society during the year under the presidency of Dr. Bailey B. Sory, Jr. Ten meetings of the society have been held during the year. Increased attention should be had to the matter of attendance at county medical society meetings. The number of physicians, members of the society, who live at some distance from West Palm Beach, where the meetings are held, has operated to keep the record of attendance lower than it should be. Special mention should be made of the record of service of Dr. Lloyd J. Netto, who is retiring as secretary of the society, from a position which he has held for several years.

The membership of the Palm Beach County Medical Society at the end of 1937 was 56. Physicians practicing in the county, not members of the society, number 15, of which five are colored.

Broward County Medical Society reports an excellent year, with renewed interest in the society and the addition of several new members. One member of the society was expelled for conduct to the prejudice of medical ethics and the best interests of the medical profession. The physicians of Broward County have cooperated almost 100% in the organization and equipment of a new hospital in Fort Lauderdale, which is now in operation, adequately housed and equipped, and filled with patients.

The cooperation of the physicians in Broward County with the full-time Health Unit has been excellent. A similar cooperation and support by the County Commissioners would do much to facilitate the smooth and efficient operation of this unit.

The membership of the Broward County Medical Society at the end of 1937 was 31. Physicians practicing in Broward County, not members of this society, number four, of which one is colored.

The first meeting of District F., Florida Medical Association, comprising the county societies of Palm Beach, Broward, Dade and Monroe, was held in 1937 in Miami. The attendance was less than it should have been, considering the location of the meeting. In-

terest in such a regional meeting was manifested by those present. The meeting was a most successful one, including addresses by our state association officers, and a scientific program. The year 1938 will see another such meeting, in October, probably in Fort Lauderdale.

Early attention should be paid by secretaries of the component societies to the matter of stimulation of attendance at these meetings of the various districts. A large attendance in itself guarantees the success and fulfills one of the major purposes of these regional meetings.

The councilor of the Eleventh District wishes to express his appreciation for the hearty cooperation of the officers of the association and its managing director, during the past year, and wishes to again assure the association of his willingness and pleasure in cooperating in the carrying out of the expressed and implied wishes of the officers of the association and of its House of Delegates.

TWELFTH DISTRICT—

Harrison A. Walker, M. D..... *Miami Beach*
Dade, Monroe.

An investigation was made of doctors who should be eligible for membership in Dade and Monroe counties and a report given to Dr. W. McL. Shaw, Chairman of the Council, and to Dr. Stewart Thompson, Managing Director of the Association.

The annual meeting of District "F", composing Councilor Districts Eleven and Twelve, or Palm Beach, Broward, Dade and Monroe counties, was held in Miami on September 3, 1937. There were 94 members, wives, and guests present at a dinner held in the Columbus Hotel.

Dr. F. K. Herpel of West Palm Beach, Senior Councilor, acted as chairman and after giving, in his preliminary remarks, the purpose of the meeting and making some explanation of the formation of the councilor districts, introduced Dr. R. N. Burch, President of the Dade County Medical Society, who gave the address of welcome. Dr. Edward Jelks, President of the Florida Medical Association, was then introduced and gave a brief but concise and inspiring address on the benefits of organized medicine and the value of cooperation of its component parts. Dr. Shaler Richardson, Secretary of the Association, gave his report.

A scientific program followed. Dr. Harrison A. Walker, Junior Councilor, was in the chair. He introduced Dr. Lloyd Netto of West Palm Beach, who gave a well prepared paper on "Ectopic Pregnancy." Dr. Kenneth Phillips of Miami, read a paper on "Fever Therapy." Dr. Shaler Richardson gave a paper, illustrated with lantern slides on "Treatment of Retinal Detachment."

The attendance was good, considering the time of year, as many men are on vacations in September. The interest was excellent and it is to be considered that the first district meeting was very successful and that each succeeding meeting will be better and more beneficial.

STATE NEWS ITEMS

Dr. Stanley Erwin of Jacksonville was named president of the Medical Staff of St. Lukes Hospital at the annual election of officers held January 13. He succeeds Dr. S. R. Norris, who headed the Staff last year. Dr. Ferdinand Richards was named vice-president and Dr. William S. Manning, secretary.

* * *

Dr. Albert H. Freeman of Ocala was recently elected a Life Member of the Florida Medical Association. Doctor Freeman, a past president, has been a member of organized medicine for the past 35 years and was recommended for Life Membership by the Marion County Medical Society.

* * *

Dr. Louie M. Limbaugh is chairman of the physicians' and surgeons' section in the Jacksonville Community Chest campaign. On his team of workers are the members of the Duval County Medical Society.

* * *

The dramatized radio broadcasts presented each week by the American Medical Association and the National Broadcasting Company will, during the month of March, feature Public Health. The March schedule is as follows:

Mar. 2—Water, Waste and Sanitation. Importance of community control of water supplies, sewage disposal and general sanitary matters.

Mar. 9 — Protecting Perishable Foods. What the community can and must do to pro-

tect fresh foods such as fish, fruits, vegetables, meats, bakery goods.

Mar. 16—Keeping Books on Health. The meaning and the importance of vital statistics, contagious disease reporting and community health records.

Mar. 23—Catching Disease from Animals. Rabbit fever, rabies, undulant fever and similar infections, and what can be done about them.

These programs are broadcast from 2 to 2:30 p. m., eastern standard time.

* * *

Dr. and Mrs. F. G. King of Jacksonville announce the birth of a daughter on January 5. Mrs. King, prior to her marriage, was Miss Evelyn Walters of Lavonia, Ga.

* * *

Dr. William S. Nichols of Lake City was recently appointed State Ophthalmologist by the State Welfare Board in connection with the aid to the blind category of its public assistance program.

* * *

Dr. John Douglas Ferrara and Miss Margaret McGraw of Jacksonville were married in that city on January 29. Doctor Ferrara, a graduate of Yale, has practiced his profession in Jacksonville for the past two years.

* * *

Dr. Thomas S. Anderson of Live Oak, a Life Member of the Association, was a visitor in the headquarters office on Wednesday, January 12. Doctor Anderson seems to have entirely recovered from his accident and is not using a cane at the present time. His certificate of membership in the Florida Medical Association is dated 1890.

* * *

Dr. and Mrs. E. Clay Shaw of Miami announce the birth of a daughter, Gail, on Thanksgiving Day, at St. Francis Hospital.

* * *

Dr. William H. McCullagh of Jacksonville addressed the mental hygiene study group of the American Association of University Women at its first meeting on January 18. The mental hygiene group of the A. A. U. W. will conduct a series of meetings for the study of mental health, consisting of lectures, informal talks, discussions, and book reviews.

Dr. and Mrs. Frank Voris of Miami Beach announce the birth of a daughter, Scarlet, on December 1, at St. Francis Hospital.

* * *

The American Board of Ophthalmology will hold its 1938 examinations as follows:

San Francisco, June 13.
Washington, D. C., October 8.
Oklahoma City, November 15.

Applications should be filed immediately. Required number of case reports must be filed at least sixty days prior to date of examination. Application blanks can be procured from Dr. John Green, 3720 Washington Ave., St. Louis, Mo.

* * *

The Southeastern Surgical Congress will conduct one of the most extensive postgraduate assembly courses in the different surgical specialties ever held in the South, March 7, 8 and 9, 1938 at Louisville, Kentucky, according to Dr. B. T. Beasley, Director General of the Congress. Similar assemblies have been held during the past eight years in Atlanta, Birmingham, Nashville, Jacksonville, Charlotte and New Orleans. The Louisville Assembly of the Congress will emphasize the postgraduate side of surgery, which will characterize this meeting as a most outstanding postgraduate surgical teaching unit. Some of the nation's greatest surgical teachers will lecture and demonstrate with slides and moving pictures various phases of surgery. Dr. J. L. Borland of Jacksonville will take part in the program. There are 53 doctors in Florida who are Fellows of the Congress. The completed programs will be ready for mailing by the first of March. For a copy of the program and complete information, write Dr. B. T. Beasley, 701 Hurt Building, Atlanta, Georgia.

* * *

Dr. W. M. Rowlett, Secretary of the State Board of Medical Examiners, reports that of the sixty-two doctors who took the examination in Jacksonville, November 15-16, 1937, forty-three passed and nineteen failed. Eighteen applicants were denied the privilege of taking the examination for various reasons: graduates of low grade medical colleges, foreign physicians who had not become American citizens and those physicians who did not possess past clean medical records.

Among those who were refused was a Chicago physician who pleaded guilty in 1934 to a federal charge of harboring John Dillinger and Homer Van Meter, and operating on the one-time "Public Enemy No. 1" in an attempt to obliterate his fingerprints and alter his facial features.

Charles W. Anderson, 8 S. E. 8th Street, Miami. Emory, 1935.
J. W. Annis, Mayo Clinic, Rochester, Minnesota. Minnesota, 1935.
James Albert Bradley, 111 West Cheves St., Florence, South Carolina. Pennsylvania, 1927.
Harold Hugo Brueckner, State Tuberculosis Sanatorium, Orlando. Michigan, 1932.
Jerome J. Coffee, Hollywood. Georgetown, 1932.
Isadore Leo Fishbein, St. Vincent's Hospital, Jacksonville. Arkansas, 1937.
Bessie Sinclair French, 292 N. W. 32nd St., Miami. Illinois Medical, 1913.
Laura C. Gaetjens, 203 West Gregory St., Pensacola. Columbia, 1935.
Wade H. Garner, Troy, Alabama. Maryland, 1927.
E. Borland Gill, 305 Vallette St., New Orleans, La. Tulane, 1923.
Irving Greenberg, South Fallsburg, New York. Bellevue, 1917.
Charles N. Harper, 116 East 53rd Street, New York City, Virginia, 1915.
O. R. Holters, Asbury Park, New Jersey. Bellevue, 1919.
Roderic O. Jones, Baker Sanatorium, Lumberton, North Carolina. Duke, 1935.
Bernard E. Kane, Lynne, Florida. Chicago, 1933.
Simon I. Kemp, St. Vincent's Hospital, Jacksonville. Georgetown, 1934.
Lawrence H. Kingsbury, Florida State Sanatorium, Orlando. Louisville, 1934.
Edward L. Kinney, Orange General Hospital, Orlando. Virginia, 1933.
Bernard Kline, 1412 Euclid Avenue, Miami Beach. Edinburgh, Royal College of P. & S., 1933.
Carlton Anderson Lee, 922 Citizens & South. Bank Building, Atlanta, Ga. Emory, 1917.
A. L. Lewis (col.) Homer Phillips Hospital, St. Louis, Mo. Meharry, 1934.
George Light, Route 4, Box 367, Jacksonville. Arkansas, 1925.
David B. Manley, Roanoke Hospital, Roanoke, Virginia. Virginia, 1937.
Paul Mapother, Jackson Memorial Hospital, Miami. Louisville, 1935.
Lawrence H. McCalla, Greenville, South Carolina. Georgia, 1921.
Franklin McElheny, Grady Hospital, Atlanta, Georgia. Emory, 1936.
Norman W. McLeod, Jr., Woman's Hospital, New York City. Pennsylvania, 1934.
R. Bradner Mertz, Citizens Bank Building, Tampa. Minnesota, 1935.
Joseph F. Montague, 139 East 36th Street, New York City. Bellevue, 1917.
A. E. Moore, General Hospital, Cincinnati, Ohio. Tulane, 1931.
David A. Nathan, Hamilton Co. Tuberculosis San., Cincinnati, Ohio. Cincinnati Medical, 1936.
James R. Norton, 1347 Belvedere Avenue, Jacksonville. Arkansas, 1936.
William G. O'Donnell, Victoria Hospital, Miami. Georgetown, 1935.
Carl T. Olson, Wyndmere, North Dakota. Rush, 1919.
Severn R. Ombres, Good Samaritan Hospital, West Palm Beach. Pennsylvania, 1936.
Martle Foy Parker, Boaz, Alabama. Rush, 1936.
James N. Patterson, 3858 Drake Avenue, Cincinnati, Ohio. Cincinnati Medical, 1929.
Russell W. Ramsey, Walter Reed Hospital, Washington, D. C. Jefferson, 1934.
Gerald J. Walsh, Tampa Municipal Hospital, Tampa. McGill, 1937.
Harrison R. Wesson, Lawrenceville, Virginia. Virginia, 1929.
Fred E. Whaley, Tampa Municipal Hospital, Tampa. Tennessee, 1937.
Paul L. White, Tampa Municipal Hospital, Tampa. Ohio, 1936.
Wesley W. Wilson, 205 Memorial Boulevard, Box 1, Tampa. Duke, 1937.

* * *

The American Physicians' Art Association, a national organization of medical men who have ability in the fine arts, will hold a first national exhibition in the San Francisco Museum of Art, San Francisco, California, in June, 1938. The A. M. A. convention will be held in that city June 13-17. All entries close April 1. Any physician interested should communicate at once with the Secretary of the American Physicians' Art Association, Suite 521-536 Flood Bldg., San Francisco.

* * *

Dr. A. J. Logie of Jacksonville was guest speaker at a meeting of the Polk County Medical Society held January 12. He presented a paper on "The Value and Significance of the Tuberculin Test."

* * *

Dr. and Mrs. L. A. Klein of Live Oak have returned from an extended trip through the middle west where Doctor Klein visited the hospitals and clinics in the important medical centers.

* * *

Dr. and Mrs. A. J. Ferlita of Tampa, announce the birth of a son, Ross James, on September 7, 1937.

* * *

Dr. L. Lambdin of St. Petersburg announces the reopening of his office at 332 Fourth Street North. His practice is limited to diseases of the heart and circulatory system.

Dr. and Mrs. S. Ward Fleming have returned from a six weeks' vacation in the Carolinas and New York. Doctor Fleming also attended the annual meeting of the American College of Surgeons in Chicago.

* * *

Dr. and Mrs. C. D. Whitaker and children of Marianna spent the last week in December visiting at Belle Glade and other points in South Florida.

* * *

Dr. Lucien Y. Dyrenforth of Jacksonville recently received a certificate in Clinical Pathology and Pathologic Anatomy from the American Board of Pathology.

* * *

Dr. H. L. Harrell of Dade City and Miss Frances Allen of Lewisburg, Tenn. were married on November 27, 1937. Doctor Harrell has recently become affiliated with the Pasco-Hernando-Citrus County Medical Society and the State Association.

* * *

Dr. Fred Mathers announces the opening of offices for the practice of internal medicine at 323 Exchange Building, Orlando.

* * *

Dr. J. J. Guerra announces the opening of offices in the First National Bank Building, Tampa. He was formerly connected with the Vinson Urological Clinic.

* * *

Dr. R. D. Thompson of Orlando, superintendent of the New Tuberculosis Sanatorium, addressed the members of the Polk County Medical Society at a meeting recently. He discussed "Tuberculosis and the State Sanatorium."

* * *

Dr. A. B. Quasser of Jacksonville died on February 3, after an extended illness.

* * *

Dr. L. M. Anderson of Lake City died at his home Friday, January 21. Doctor Anderson was a Life Member and a past president of the Florida Medical Association and will be deeply missed by the members of his profession.

RESOLUTIONS ON THE DEATH OF DR. J. M. MANN

Jacksonville, Florida
November 15, 1937

Whereas, the Florida State Board of Medical Examiners has suffered in the sudden and untimely death of Dr. J. M. Mann, a most valuable, stalwart, respected and beloved member, and

Whereas, Doctor Mann was a faithful and efficient member of the Board since its organization, serving as its honored president.

He gave cheerfully of his time and talent to every cause intended to strengthen and benefit the Board, never having been absent from a single meeting of the Board since its creation and has always been a true disciple of the principles of organized medicine which he has practiced as well as preached, always maintaining the highest standard of ethical relationship.

Resolved, That in the death of Doctor Mann the Board has lost a member whose place will be hard to fill, whose active interest will be sadly missed, whose devotion to its best interests has been largely responsible for its development and influence in the establishment of the present high standard of medical licensure.

Resolved, That we deplore the loss of Doctor Mann and feel the loss of this member very deeply, that each member of the Board is grieved, and extend to his family our deepest sympathy.

Be It Further Resolved, That the State Board of Medical Examiners of Florida offer condolence to the bereaved family in this hour of sadness over their departed member and that a copy of these resolutions be sent to his bereaved widow, family, and the Florida Medical Association.

Carl Williams, M. D.,
J. E. Crump, M. D.,
S. G. Hollingsworth, M. D.,
Committee.

COMPONENT COUNTY SOCIETIES

ALACHUA COUNTY MEDICAL SOCIETY

At the election of officers held by the Alachua County Medical Society recently, the following were chosen to head the society for the coming year:

President—Thomas A. Snow, Gainesville
Vice-Pres.—J. E. Maines, Sr., Lake Butler
Sec'y-Treas.—H. M. Merchant, Gainesville.

Dr. J. L. Summerlin of Gainesville and Dr. W. E. Murphree of Raiford will serve as delegate and alternate, respectively, at the next annual meeting of the State Association.

* * *

BAY COUNTY MEDICAL SOCIETY

At the annual meeting of the Bay County Medical Society, the following officers were elected to serve for 1938:

President—W. J. Blackshear, Panama City
Vice-President—Don S. Fraser, Panama City
Sec'y-Treas.—W. C. Roberts, Panama City
Delegate to State Convention—D. M. Adams
Alternate Delegate—W. C. Roberts.

* * *

BREVARD COUNTY MEDICAL SOCIETY

The Brevard County Medical Society recently held its annual Election of Officers, with the following result:

President—G. E. Christie, Titusville
Vice-President—W. J. Creel, Eau Gallie
Sec'y-Treas.—I. K. Hicks, Melbourne.

* * *

COLUMBIA COUNTY MEDICAL SOCIETY

The Columbia County Medical Society recently chose its officers for the ensuing year.

Those elected to serve are:

President—W. S. Nichols, Lake City
Vice-President—W. M. Ives, Lake City
Sec'y-Treas.—H. S. Howell, Lake City

* * *

DADE COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Dade County Medical Society was held Tuesday, January 4, at 8:30 p. m., in the Assembly Room of the Florida Power and Light Building. President Arthur H. Weiland presided. Dr. James Nugent presented a paper on "Pathological Factors in Gall Bladder Disease." The following applications for membership were read and the applicants unanimously elected to membership: Drs. Maurice A. Kugel, Milton S. Saslaw, Calvin H. Short, and Richard G. Tietze.

DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society held its regular meeting on the evening of Febuary 1 in the Library of the State Board of Health. A symposium on Sulfanilamide comprised the scientific program, being presented as follows:

1. Sulfanilamide Treatment in Urology —E. T. Sellers.
2. Sulfanilamide Treatment in Pediatrics—Thomas Buckman.
3. Sulfanilamide Treatment in Diseases of Ear, Nose and Throat—J. C. O'Dell, Jr.

The discussion was opened by Drs. B. F. Woolsey, J. E. Gammon, W. H. McCullagh, and Raymond H. King.

* * *

LAKE COUNTY MEDICAL SOCIETY

Dr. Robert B. McIver of Jacksonville was the guest essayist at the regular meeting of the Lake County Medical Society held at Leesburg, January 6. The title of Doctor McIver's paper was "Surgical Lesions of the Kidney" and was illustrated with lantern slides and motion picture films.

* * *

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY

Dr. Robert B. McIver and Dr. James L. Borland of Jacksonville were guest speakers at the regular quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, held in Quincy at the Woman's Club, January 20 at 3 p.m. The subject of Doctor McIver's paper was "Perinephritic Abscesses"; Doctor Borland's paper was on "Differential Diagnosis of the Dysenteries." Both papers were illustrated by lantern slides.

* * *

MARION COUNTY MEDICAL SOCIETY

At the annual Election of Officers held by the Marion County Medical Society, the following were chosen to head the society for 1938:

President—Carney W. Mimms, Ocala
Vice-President—Edwin C. Hanson, Belleview
Sec'y-Treas.—R. C. Cumming, Ocala
Delegate to State Convention—E. G. Peek.

* * *

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

The annual meeting of the Pasco-Hernando-Citrus County Medical Society was held

Thursday evening, January 13. The following officers were elected:
President—S. C. Harvard, Brooksville
Vice-President for Pasco County—
William Haywood Walters
Vice-Pres. for Citrus County—Claude Carter
Sec'y-Treas.—G. R. Creekmore, Brooksville

Dr. S. C. Harvard was selected as Delegate to the next convention of the State Association, with Dr. W. Wardlaw Jones as Alternate Delegate. The Councilors elected were: George A. Dame for Citrus County; H. L. Harrell, for Pasco County; A. C. Coogler for Hernando County.

The members present bowed their heads in memory of Dr. A. B. Cannon and Dr. Kilpatrick Cross, former members, who died in 1937.

Interesting case reports were presented by Drs. W. W. Jones, W. H. Walters, S. C. Harvard, Claude Carter, George A. Dame and H. L. Harrell.

Doctor Walters invited the society to meet with him at Lacoochee, Thursday evening, February 10.

* * *

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society held its first meeting of January at the Shrine Club on the 6th. The program consisted of two papers: "700 Temperature Readings on School Children" by Dr. Councill C. Rudolph, and "Report of Dedication of Tuberculosis Sanatorium" by Dr. A. S. Anderson.

At the meeting of the Society held on the evening of January 21, the following program was presented: "New Method for Testing Cardio-Respiratory Efficiency" by Dr. F. F. Kumm, "New Tuberculosis Sanatorium" by Dr. A. S. Anderson.

* * *

ST. JOHNS COUNTY MEDICAL SOCIETY

The St. Johns County Medical Society, at a recent meeting, elected the following officers to serve for 1938:
President — John J. Spencer, St. Augustine
Vice-President—G. Walter Potter,
St. Augustine
Secretary—Vernon A. Lockwood,
St. Augustine
Treasurer—A. C. Walkup, St. Augustine
Delegate to State Convention—
Herbert E. White
Alternate Delegate—Charles C. Grace

ABSTRACT DEPARTMENT

Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.

Treatment of Carcinoma of the Cervix by the Combined Use of Relatively Small Amounts of Radium and Deep X-ray — Murphey, David R., Jr., Tampa, *Surg.* 2:82 (July) 1937.

Cancer of the cervix may be treated with radium, using a large amount over a short period of time or a small amount over a prolonged period. Both are usually supplemented with deep x-ray therapy.

The former method in general is obviated by lack of adequate amounts of radium in all but the very large hospitals, hence the second is the more practical and the author discusses the various ways in which this method is used at the present time.

It is important that the initial dose be adequate as neoplastic cells sensitive to radium become more resistant to these rays with sublethal dosage and this resistance increases with each treatment and eventually caustic dosage, with subsequent massive sloughs, becomes necessary. This adequate dosage varies and is difficult to determine.

The two methods in general use are: (1) The intracervical tandem in which .05 to .1 Gm. of radium is simply inserted into the cervix for a total dosage of from 2,000 to 3,000 mg. hours. An effective dose is given only opposite the center of the tubes and does not extend beyond the limits of the cervix. This method is not applicable to curable cases and can be of value only for palliation. (2) Regaud's. This method necessitates an investment in radium of only $3,750 to $4,500, and produces a total dosage of from 8,000 to 9,000 mg. hrs. This dosage is so distributed as to give a relatively adequate exposure both to the site of the lesion and to the important routes of spread. Its main disadvantage lies in the discomfort to the patient and the relatively long hospitalization (5-7 days).

Hypoglycemic Therapy — Smith, H. Mason, Tampa, *J.A.M.A.*, 108:1959 (June 5) 1937.

The treatment of schizophrenic states by



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hypoglycemia induced through the use of insulin in shock dosage has proved to be the most efficient agent in these conditions.

The author emphasizes the necessity for adequate attendance of the patient after shock dosage has been reached and selects a number of his cases to show not only the beneficial after-effects but the emergencies which have to be met during the period immediately following shock dosage.

Benefit is thought to be due to stimulation of the carbohydrate metabolism of the central nervous system, with consequent improvement of function.

Psychoneurotics of long standing as well as schizophrenics are being treated in this manner, by the author with good results. In treatment of the neurotics, however, the insulin is neutralized before shock occurs.

Temperature and the Growth of Hair—Eaton, Paul, and Eaton, Mary Wright, Jacksonville, *Science*, 86:354 (October) 1937.

"Casual observation of the variation in the growth of facial hair at different seasons of the year suggested its measurement. An experiment was planned, involving the measurement of the hair shaved from the same part of the face at approximately the same hour and with the same technique every day for one year (the subject, P. E., a florid male, aged 59)."

The site chosen was an area of about one square inch immediately in front of the ear; measurements were made with an ocular micrometer. "Each daily value was linked with the average temperature of the preceding day, as furnished by the U. S. Weather Bureau." The following table shows the result of this experiment:

Month	Mean Temperature	Measured Growth
January	58°	.305 mm.
February	54°	.386 mm.
March	61°	.404 mm.
April	70°	.458 mm.
May	74°	.464 mm.
June	81°	.516 mm.
July	83°	.533 mm.
August	82°	.538 mm.
September	79°	.545 mm.
October	73°	.533 mm.
November	64°	.495 mm.
December	60°	.375 mm.



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†VITAMIN D	134 U.S.P. UNITS	*SMALL AMOUNT; VARIABLE	134 U.S.P. UNITS
†CALCIUM	0.15 GRAM	0.24 GRAM	0.39 GRAM
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WOMAN'S AUXILIARY NEWS

Text of a Letter from the Chairman of Public Relations, Mrs. W. J. Barge:

In some states Health Institutes have been held very successfully, sponsored by Auxiliaries, and I am therefore sending a request to all Public Relations Chairmen advising that each County Auxiliary in Florida sponsor a Health Institute. Start planning for it *now*. Consult your Advisory Board as to the most appropriate time and place to hold this all-day meeting. Select authentic speakers from among the doctors, dentists, pharmacists and nurses. Give it wide publicity. If possible, have it announced on the radio. At each of these institutes there should be a lecture on cancer as a part of our educational work.

Mrs. J. Ralston Wells, State Commander, Women's Field Army, P. O. Box 9, Daytona Beach, will be pleased to cooperate with you on the cancer program.

As many of the Auxiliaries are sponsoring a tuberculosis program, the local Tuberculosis Associations have offered their assistance by giving five to fifteen minute talks for clubs, P. T. A. meetings and radio, and also literature to be distributed.

Please see that the American Medical Broadcasts of health dramas are secured by your station. These programs are being dedicated "To America's Schools, Your Health," and should be given a lot of publicity by all County Auxiliaries. If possible, arrange to have a member of your Auxiliary go before the public schools and explain the nature and purpose of the health programs. Try to get the health education department in each school to secure a radio for the purpose of deriving

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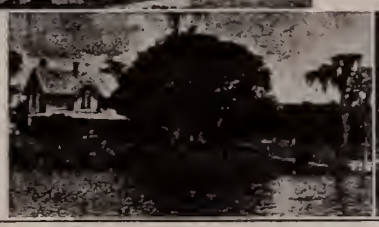



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all the benefit possible from these health lectures. The American Medical Association program will be presented in nine groups of four programs each, which began October 30, 1937 and will run through June 15, 1938. A program will be broadcast each Wednesday from 2 to 2:30 P. M. For further information write to your State Chairman, Mrs. W. H. Spiers, 36 W. Copeland Street, Orlando.

Allow two minutes at each meeting for your Hygeia chairman to present the Hygeia magazine. She should read as many articles in Hygeia as possible and be able to make some interesting comment on each . This will stimulate an interest among members to want to read it. Then, too, this information will keep members well informed about Hygeia so they can recommend it to others as the best health magazine on the market. I do hope that your Auxiliary will be able to sell its quota of subscriptions this year. Be sure to cooperate with your State Hygeia Chairman, Mrs. J. H. Mitchell, 1436 Avondale Avenue, Jacksonville. See that the Hygeia magazine is placed in public schools, libraries, hospitals, and public offices.

* * *

DUVAL COUNTY

The January meeting of the Woman's Auxiliary to the Duval County Medical Society was held Friday afternoon in the Party House with Mrs. Gordon H. Ira, Mrs. E. W. Veal and Mrs. S. M. Copeland as hostesses. Dr. Thomas M. Palmer was the guest speaker, his subject being, "Childhood Tuberculosis."

Doctor Palmer, who was introduced by Mrs. F. W. Krueger, illustrated his talk with slides and x-ray films, and was assisted by Miss Gladys Malcolm, executive secretary to the Duval County Tuberculosis Association. In his talk Doctor Palmer showed how easily tuberculosis may be transmitted in the family and school. He brought out the importance of a physical examination being thorough, and emphasized the value of the tuberculin test and of the x-ray.

At the close of the business session, delicious refreshments were served. Twenty-six members attended the meeting.

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BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

I. CLEANSING OPERATIONS

● As reference to a recent text on canning will disclose (1) the details of commercial canning procedures will vary from product to product. There are, however, certain basic operations which are included in practically all canning procedures. In the belief that they may prove of interest, it is our intention to describe in broad detail the nature and purposes of these essential operations.

One of the first and most important steps in commercial canning is the thorough cleansing of the raw food material received at the cannery. The purpose of such an operation is, of course, immediately evident, namely, to remove soil, dirt or other inedible substances which may be present. However, cleaning also serves to reduce substantially the load of spoilage bacteria with which Nature usually endows raw foods.

Commercially, cleansing is effected in a variety of ways. In general, however, water washers specifically designed for the various types of products are used. In these machines, the raw food material is subjected to high-pressure sprays or strong flowing streams of potable water while passing along a moving belt or while being tumbled by agitating or revolving screens. Sometimes a "flotation" type of washer is also used to remove chaff or similar material. With certain products, water washing is preceded by a "dry" cleaning treatment in which adhering soil and dirt is mechanically removed from the food by revolving or agitating screens, or by strong air-blasts.

Also, in certain canning procedures, operations whose basic functions are not primarily to clean the raw material may also exert a cleansing effect. Thus, the "blanch" or scalding treatment accorded many products serves to clean the food, as does the water spray sometimes applied to foods after the blanch.

Modern canners know the necessity of thorough cleansing of the raw materials they use. They appreciate that thorough cleaning and removal of extraneous material decreases the load of spoilage organisms which must be destroyed by the heat processes to which all canned foods are subjected. They also appreciate the necessity of maintaining strict plant and equipment sanitation to destroy spoilage bacteria which may be carried in by raw foods.

Because of the efficient cleansing of raw materials and close attention to the other important operations in the commercial canning procedures, modern canned foods must be ranked among the most wholesome foods coming to the American table. (2)

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230 Park Avenue, New York, N. Y.

(1) 1937 Appertizing or The Art of Canning, A. W. Bitting, The Trade Pressroom, San Francisco.

(2) Preventive Medicine and Hygiene, M. J. Rosenau, Appleton-Century Co., New York.

This is the thirty-third in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

One of a series of advertisements prepared and published by PARKE, DAVIS & CO. in behalf of the medical profession. This "See Your Doctor" campaign is running in *The Saturday Evening Post* and other leading magazines.



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OF MANY BUSINESS MEN

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That's why it usually is so difficult to get such a man to pay proper attention to his health, even though he is troubled by persistent signs and warnings that something is wrong.

For at any suggestion that he heed these warnings—that he see his doctor—he says: "Yes, yes, I suppose you're right. But what if the doctor should order me to stop work for awhile? Who'd take care of my job? What would happen to the business?"

And the irony of it is that by his attitude he is inviting the very thing he fears! For one of the surest ways of encouraging a *serious* sickness is to neglect a seemingly *small* one. Heart and other organic diseases, stomach ulcers, and nervous disorders—diseases to which men in the so-called "prime of life" are particularly susceptible—thrive on neglect.

When you see your doctor he may, to be sure, prescribe a short rest. But isn't that better than a *forced long* rest later? He might say: "Take things a little easy. Leave the office an hour earlier at night." But isn't that better than driving on relentlessly until you're *carried* out of the office?

Let us hope, of course, that your disturbance will turn out to be a minor one—and that its treatment will be simple, its correction rapid. But whatever is wrong, you'll be better off if you start correcting it before it becomes really serious. The most sensible thing you can do, therefore, is to see your doctor *now*.

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RECENT ADVANCES IN THE DIAGNOSIS AND TREATMENT OF BRONCHIAL ASTHMA*

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A review of recent literature on asthma leaves us in a maze, because of the numerous theories and their perplexing pathway of thoughts. It is difficult for us to attempt to evaluate the abundant supply of therapeutic measures that have been introduced. Briefly, I shall outline some of the advances as obviously the time allotted on this program does not permit an extensive review of all the worthwhile investigations.

For a systematic review of this disease, I feel we should first consider the etiological classification. Cooke[1] suggests the following: allergic, and non-allergic.

ALLERGIC

I Inhalants—Animal dander-pollens, dust, etc.
II Ingestants—Foods and drugs.
III Absorptions from foci-bacterial proteins.
IV Subcutaneous or intravenous injection-therapeutic sera.

NON-ALLERGIC

I Pathological, as bronchitis, pulmonary tuberculosis, enlarged bronchial glands, etc.

This appears to be a very suitable classification from an etiological standpoint as it covers the causative factor according to our present-day knowledge.

What disease must we consider before making a diagnosis of asthma? Maytum[2] outlines approximately forty-five conditions of the respiratory system which may be mistaken for asthma. A careful detailed history of the patient cannot be over-emphasized.

Rackemann[3] devotes an entire paper to this phase in an article in the Journal of the American Medical Association. The patient should be subjected to thorough physical examination and detailed inspection of the systems in which pathology is suspected. Roentgenological examination with accompanying laboratory data may lead to the etiological factor very early.

Various methods have been advised for the determination of allergic responses, among which are: the cutaneous, the intracutaneous, the ophthalmic, nasal, inhalation, and contact.

Vaughan[4] noticed there was a leucopenia following ingestion of milk by an individual sensitive to milk. Later he published his observation of sixty cases which definitely shows a relative leucopenic index following ingestion of food to which the patient is allergic. Rinkel[5] confirming Vaughan's observation, found that in 81% of the cases, the food corresponded to the symptoms.

Zeller[6] concurs in their findings. In twelve cases which he studied he found the method to have 21% more diagnostic value than the same number of skin tests with foods, and is of more value than the elimination diets.

Alexander[7] reviewed 11,443 cases of allergy in forty-four workers and found 52.7% positive skin reactions in bronchial asthma. From the above, we can readily observe we have not reached a satisfactory method of investigation.

In outlining the advancement in the therapy of bronchial asthma, I will endeavor to classify them in five headings: medical, surgical, physiotherapy, vaccine, allergic protein.

For the past three decades the supposed asthma cures have steadily increased. These are tried with successes and failures but we return eventually to our reliable adrenalin which can usually be depended upon to relieve a paroxysm.

Graeser and Rowe[8] have demonstrated that the inhalation of 1:100 epinephrine produces relief in certain asthmatic conditions. This simple discovery has revolutionized the ad-

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ministration of adrenalin to many, but the ultimate effects of repeated use of this method is to be watched.

Rappaport[9] and his associates observed that large doses of viosterol was very effective as an adjuvant treatment. Rackemann[10] confirms this by stating a marked improvement is seen as soon as his patients are able to take an adequate amount of well-rounded diet. Vitamin C has been recommended by many foreign investigators with good results.

The use of 80% helium and 20% oxygen for asthma has been suggested by Dr. Barach.[11] Good results have been obtained due to lightness and low density. It is used extensively in obstructive lesions of the respiratory passages, but owing to its cost and the requirements of special equipment, it has not received wide attention.

Wegierko[12] of Paris has treated forty patients suffering from bronchial asthma with insulin shock therapy. He advocates 40 units of insulin before breakfast, or seven hours after a meal, preferably during a paroxysm. He observed an improvement in all cases, and complete cessation of the attacks in some instances. The mechanism of action according to the author is bronchial dilation!

Recently there has been placed on the market a synthetic product which has many analogous properties of epinephrine; it is known as propadrin hydrochloride. It is supplied in three forms. I have had good results with the capsule form. These are administered daily, appear to lengthen the intervals between paroxysms and lessen their severity. The unfavorable systemic effects following adrenalin administration have not been noticed with this product.

The surgical treatment does not seem advisable until the mechanism of the paroxysm is more clearly understood. Levin[13] recently recommended the treatment of bronchial asthma by dorsal sympathectony. He injected 2.5 cc. of alcohol into the rami at a dose, and by the same method destroyed the upper thoracic ganglionated trunk, in twenty-three cases of severe asthma. He reports complete relief in 75% of cases and varying degrees of improvement in the rest.

The intratracheal injection of iodized oil continues to be recommended by Balyeat[14] and his associates, who report fifty cases with good results in thirty-five. Anderson[15] in a series of two hundred and sixty cases gives us a clear resume of this field. He reports complete relief for one to eight years in 90% of the uncomplicated cases. He emphasizes the importance of removing the secretions, by frequent injections of the oil, to insure patency of the tubes. His results appear very convincing.

This from of treatment, in my opinion, is very good in advanced cases of bronchial asthma where there is considerable secondary pathology producing tenacious sputum or purulent mucus. Often better results are accomplished by small biweekly injections than by large amounts given less frequently. It must be borne in mind that these injections are not without danger. When there is doubt, the allergic patient can be tested with all the drugs used during the procedure.

Fever therapy has been used as the treatment for many conditions. Krusen[16] in his review of recent literature collected 117 cases which were treated by fever therapy, 104 with favorable results. He concludes that hospital fever therapy is justified in treating intractable cases where other means have failed.

Phillips[17] regards hyperpyrexia as a most valuable adjuvant treatment, recommending at least ten treatments for any lasting results. He has found that lower temperature with shorter intervals and more frequent treatments to be of greater value.

Vaccines have been used for a number of years with varying degrees of success. Autogenous vaccines secured from the paranasal sinuses and bronchi appear to be more successful. This may be due to the composition of the stock vaccines. They usually consist of the more prevalent organisms rather than some of the more unusual ones which may be the incitant. Cohen[18] emphasizes the fact that we don't always get skin reactions from our known specific vaccine. It is necessary sometimes to give it a therapeutic trial to warrant its discontinuance. Vaccine therapy used in conjunction with allergic therapy is often successful.

Ionization has many followers and many opponents. It is a very simple procedure of passing a low milliamperage current through

the nasal mucous membranes. Many solutions have been used; adrenalin, histamine, zinc sulphate, calcium sulphate, and others. From a personal standpoint I have not had startling results. It is the indicated therapy for the nose and paranasal sinuses, when all other methods have failed.

Hansel[19] reports a summary of the literature on this subject and he concludes that in allergic conditions due to inhalation, but without explainable etiology, ionization may be indicated. It is the concensus of opinion that ionization alters the mucous membranes of the nose and renders them insensitive to allergins for a varying period of time. Alexander[20] demonstrates that nasal ionization has no effect on the reagins in the blood and the cutaneous test remains positive throughout to those allergins.

Feinberg[21] recently made an important contribution in his study of mold allergy. In a series of 243 patients suffering with respiratory allergy, he found 68, or 28%, gave a positive cutaneous reaction to fungus extracts. The majority of these fungi were ordinary molds whose spores are commonly found in the air. He tested 590 suffering from allergic respiratory conditions with yeast and found 65 or 11%, positive. From his studies he concludes that fungus-sensitive patients are usually sensitive to house dust, but all patients sensitive to the latter are not sensitive to fungus. This is probably due to house dust containing one or more fungi. It is my opinion that if we in Florida will consider this phase of allergy, we will be rewarded by some unusual findings.

Histamine therapy has been used rather extensively in Europe for the treatment of asthma, but it has not gained wide attention in this country. It presents a form of protein therapy which has caused considerable comment and many controversies.

Histamine is a decomposition of protein. It is found in almost all animal tissues. The substance is liberated by the action of about thirty different types of putrefactive bacteria, and is present in the intestinal canal in considerable quantity.[23]

Epstein[24] points out that using various methods of investigation it had been shown that histamine produces obstruction of the respiratory passages of the guinea pig by a direct constrictory effect on the bronchioles. The bronchi and trachea appear to take no part in the obstruction, for they may actually be relaxed by histamine. Schilf,[25] in his studies, measured changes in bronchial secretion in terms of the weight of water vapor liberated into the passing air from a given area of bronchus in unit time. He found epinephrine has no effect on bronchial secretion; histamine causes a decrease in secretion.

Stahl and Masson[26] report that histamine given by intradermic injections in doses of from one to three mg. diminishes the dyspnea of asthmatic crises. Intramuscular injection aggravates the trouble. Application of histamine to scarified patches on the skin has a similar effect to that of the intradermic injection.

Dzsinich[27] who has done considerable work in this field calls attention to the similarity between histamine shock and anaphylactic shock and points out that on the basis of this observation it was assumed that histamine plays a part in allergic conditions. The investigations that were made in connection with this hypothesis corroborated the assumption of the important role of histamine in the allergic reaction; namely, that histamine is liberated by the cells in the sensitized organism. It is assumed that in asthma histamine is liberated by the vascular cells of the bronchi; in urticaria, by those of the skin; in hay fever, by those of the nasal mucous membrane; and in migraine and epilepsy, by the vascular cells of the brain. The histamine and histamine-like substances thus liberated supposedly elicit endogenously the local and general symptoms of these disorders. If this stand is taken, it seems justified to assume that allergic persons can be desensitized against this endogenously produced histamine by the exogenous introduction of small doses of histamine.

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THE ROUTINE STUDY OF FRESH, UNSTAINED VAGINAL SECRETIONS IN OBSTETRICS AND GYNECOLOGY*

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It has been repeatedly stated that about twenty-five per cent of the general practitioner's work is gynecology. Certainly this is true of his office practice. A large number of these patients show some alteration in the character of the vaginal secretions. Often a burning, itching, scalding discharge is the primary symptom. Others, especially when consulting their family physician will attempt to conceal the presence of a vaginal discharge and seek an examination "just to see if everything is all right", feeling that their doctor will certainly notice anything unusual. Many a wise family physician will immediately detect this subterfuge and get a true history, but occasionally he will be misled. Furthermore, it is well known to all of us that nine out of ten women will take a thorough douche and tub bath before presenting themselves for a pelvic examination, thus getting rid of vaginal secretions which would otherwise be noticed immediately on examination. At any rate the physical character of a given vaginal secretion is subject to wide variation.

It is not my purpose to enter into a discussion of the technical or controversial aspects of this problem, but rather to point out the importance of a simple office routine, neither difficult nor time consuming (an unskilled office assistant may be quickly taught to do the work for you) which, in my opinion, is an absolutely essential part of every pelvic examination. I refer to the study of fresh vaginal secretions for Trichomonas and Monilia.

About ten per cent of all women[1] and approximately eighteen per cent of pregnant women[2] show one of these parasites. In Florida, with constant warm weather and subtropical climate, I believe the incidence is higher. My own records show twenty-two per cent incidence in obstetrical cases and thirty-one per cent in gynecological cases.

*Read before the Florida East Coast Medical Association, Ft. Pierce, November 13-14, 1936.

Thirty-one per cent is a high figure and, obviously, does not apply in general practice. The ratio between Trichomonas and Monilia is approximately 3:1 in obstetrical and 5:1 in gynecological cases.

METHODS

Hanging drops are made before any examination is begun, because I feel that the Trichomonas is frequently killed by admixture with lubricating jelly. An ordinary cotton applicator is moistened from a small test tube containing one-half inch of saline and inserted first into one fornix and then the other, dipping into the saline after each insertion and finally leaving it in the test tube. The same applicator is convenient in transferring a portion of the suspension to a slide for microscopic examination under a low power objective. At first it may be necessary to use a high power lens for identification. Although used primarily for Trichomonas, Monilia is frequently diagnosed from this preparation. I have not found it necessary to warm the saline, but this may be advisable on cold days. One may now proceed with his routine pelvic examination. After the speculum is inserted, any suspicious clumps of secretion on the vaginal walls are removed with another applicator and placed on a slide for examination to determine the presence of Monilia. Cellular debris may be removed by digestion with ten per cent sodium hydroxide for a few minutes.

(Lantern slides were used in the original presentation.)

MONILIA

Monilia albicans is a fungus composed of long, branching, segmented febrils with definite buds growing between the segments. It is best studied under the high powered objective and is frequently referred to as "yeast", to include other less common vaginal fungi. It is responsible for the well known thrush seen in infants.

The lesions in Monilia vaginitis are almost exactly similar to the lesions of thrush.[3] The mucous membrane is raw, red, and characteristic flakes, composed of masses of fungi, are scattered loosely over the vaginal surface. In some instances, a small ulcer lies beneath those flakes. Often, especially in pregnant or obese individuals, the disease spreads to the vestibule and labia majora. The discharge contains curds in a watery base and is not unlike buttermilk in appearance and consistency. Less offensive than the discharge due to Trichomonas, it is most copious premenstrually. Many cases of thrush in the newborn are traceable to a vaginal infection from the mother.

TRICHOMONAS.

The Trichomonas is a protozoon averaging about fifteen microns in length. Slightly larger than a pus cell, these organisms may be seen moving busily about the microscopic field. There is considerable controversy regarding the various types. Intestinal, buccal, vaginal and others are described. All have cilia in some form.

The Chilomastix mesnile is probably related to or identical with Trichomonas. Its definite posterior appendage is used for attachment to some nearby structure. Therefore, it does not move freely about the field as Trichomonas, but feeds first in one place and then another. Distinct ameboid motion is usually observed.

Giardia lamblia is apparently a harmless parasite when present in vaginal secretions. It is easily recognized by its graceful, arched, spiral mode of locomotion and distinct flattening. Some have found it pathogenic.

Goodall[4] describes numerous case constant variations; "pineapple," "windmill," "angler," "spin-wheel" and "seal" types are recognized. Are they all one and the same or are there a hundred varieties of this troublesome bug? Some day we will know.

The "strawberry" vagina has been described as typical of Trichomonas infestation. Innumerable tiny ulcers suggest the salt and pepper appearance of senile vaginitis. I have observed all degrees of this picture, varying from an almost imperceptible vaginitis to an ulcerated edematous, firey red and excruciatingly tender birth canal. Typically, the discharge is copious, watery, irritating, offensive and has a rather frothy consistency. It is always worse postmenstrually. This frothy character is very constant, almost pathognomonic.

There is a question as to whether the Trichomonas alone causes pathology. Symbiosis, as always, has been suggested (streptococci,[5] spirochetes and others) but almost all investigators now agree that Trichomonas, per se,

is pathogenic in women. Certainly there are wide variations in the clinical picture. I have cases on record in my office with positive laboratory findings, but absolutely no signs or symptoms, which have later developed typical symptoms. This is especially true of Monilia.

ATYPICAL TYPES

Still other and more important groups of cases harbor organisms without distinctive symptoms. Several types are worthy of discussion.

VAGINAL BLEEDING

It is now fairly well established that uterine bleeding may be caused by the Trichomonas[6] and every case of irregular bleeding or menorrhagia should have a hanging drop, especially if associated with a discharge.

Case 1

A 23 year-old white woman complained of progressive, irritating discharge since marriage four years previously. There was beginning pink spotting and occasional bleeding between periods which were regular. Examination revealed slight cervical erosion and blood stained foul discharge. Hanging drop was positive for Chilomastix (Trichomonas?). Self treatment consisted of capsules of quinine and lactose inserted each night after a warm douche. The vagina was sprayed every other day with five per cent quinine hydrobromide. In three weeks the hanging drop became negative and bleeding stopped. The patient was well one month later and has not reported again.

POST ABORTION

Very commonly we see patients who have had an abortion followed by irregular bleeding and profuse leukorrhea. Usually some of these patients require curettement. Before operation, if there is no evidence of cervical or adnexal disease, we are likely to tell this patient that she will be cured by the procedure.

Case 2

An eighteen-year old, unmarried girl had had a profuse irritating vaginal bleeding following a criminal abortion performed 35 days previously. She had a left salpingitis but the cervix was clean. The bloody vaginal discharge was quite offensive and loaded with Trichomonas. Treatment and local measures were instituted, but a curettement finally became necessary. She continued to have a profuse, irritating mucopurulent discharge which was treated appropriately and successfully. Fortunately, this patient was prepared for the necessary after-treatment and cooperated nicely.

SURGICAL PROGNOSIS

No surgeon likes to have a dissatisfied patient. These patients will come again and again into the surgeon's office, bemoaning some detail for which they were unprepared before the operation. Too frequently they will take their troubles to their neighbor or another physician.

Case 3

A 43 year old widow complained of prolonged and profuse attacks of bleeding for six months, the current one of three weeks duration and very profuse. Her uterus was slightly enlarged, but otherwise the pelvis was normal. There was a profuse bloody discharge. Following diagnostic curettage a supervaginal hysterectomy was performed. One month later she presented herself to me complaining of a profuse, irritating discharge which was loaded with Trichomonas. Appropriate treatment was instituted. My office nurse had examined the hanging drop and recorded it as positive on this patient's chart, but I overlooked the report. She had expected to be entirely well and did not like it at all.

PROGNOSIS AND TREATMENT

Monilia almost always responds to a few applications of gentian violet. One author prefers a two per cent alcoholic solution or five per cent aqueous solution.[7] I have found that aqueous solutions tend to run off the mucous membranes, especially the vestibule, while patients find alcoholic solutions uncomfortable. Two per cent gentian violet in five to ten per cent alcohol penetrates and is well tolerated. The vagina and vestibule are painted every two or three days. Three to five applications are sufficient.

Trichomonas is another story. Ultimate prognosis should be guarded. Relief of symptoms and adequate control are always attained, but recurrences are common. Never promise a permanent cure.

Any of the suggested measures—one per cent picric acid applications, silver picrate insufflations, argyrol packs, weak quinine solutions, insufflations, Devegan tablets, Alder-

son, diluted stovarsol powder insufflations, instillations of mercurochrome or hexylresorcinol—are effective in most cases if applied diligently and principles of treatment are kept in mind. These principles are: eradication of the organism, restoration of acidity and flora, restoration of vaginal mucous membranes, and elimination of sources of reinfection.

Reinfection from the intestinal tract, an infected sexual partner, fresh moist secretions on towels, clothing or toilet seats, infected gums and perhaps other sources are the greatest problem and these possible infectors should be diligently investigated in obstinate cases. An occasional application of one per cent silver nitrate is stimulating to the mucous membrane and after the menopause, estrogenic hormone (Theelin) is a powerful adjunct. Lactose does not ferment and provides an excellent food for the normal vaginal flora and mucous membrane. It should be kept in mind as an insufflation and vehicle in late treatment. Medicated douches are of little value in my experience and douches of all kinds should be infrequent. Twenty-five per cent saline douches seem helpful in very persistent or overtreated cases. During active treatment douches merely wash out your medication and decrease the vaginal hydrogen ion concentration. Weakly acid douches are often helpful in late treatment. Soda douches are detrimental. I never prescribe medicated douches in active cases and never oftener than once a day.

I prefer to begin treatment with a one per cent aqueous solution of picric acid. This is sprayed over the mucous membrane and vestibule daily until hanging drops are consistently negative. Then treatments are less frequent (insufflations are often substituted) and Devegan tablets (a proprietary preparation containing lactose, boric acid and an arsenical in satisfactory ratio) are inserted by the patient each evening after a cleansing douche. Active prescribing is discontinued at the beginning of the next menstrual period if hanging drops remain negative. Devegan tablets are inserted twice daily during the next flow and each night during the following month. I examine my patients regularly, especially after the next three periods, and advise self treatment during these menses. Obstetrical cases may be treated up to two weeks before delivery, but care to avoid overtreatment must be employed. Active cases show approximately twice the average puerperal morbidity.

SUMMARY

1. The importance of routine examination of fresh, vaginal secretions is emphasized.
2. Two common pathogens are shown with suggestions as to management.

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Ingraham Bldg.

OBSERVATION ON STUDIES OF KIDNEY FUNCTION*

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Have you ever noticed how little practical or easily understood discussion of kidney function appears in the literature read by the average physician? Information can be found, but often only with considerable difficulty. Often highly technical outlines of laboratory procedure with little mention of definite indications for use or scant clinical interpretation are met or, more discouraging still, the explorer runs into difficult and involved language covering the much debated theories of kidney function. There has been no lack of experimental work upon the kidneys. One may become generally confused by study of many of the tests that are continually being advanced. There is considerable conflict of opinion among authorities. Debate is active. And it seems in addition that certain of the tests have never reached the trial ground of practical clinical medicine.

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It is not the purpose of this paper to discuss symptom complexes or syndromes, to describe pathology of the wrecked organs as seen at autopsy, to discuss theories of urine manufacture, to enumerate with too much wearying detail the technical procedures of the tests, or even to discuss the diagnosis of kidney lesions. It is intended only to outline a simple methodical routine for detection of renal deficiency. It is earnestly hoped that it will aid in detecting previously unrecognized cases of kidney impairment or assist in determining in a satisfactory manner the degree of defect in function in known renal cripples.

The kidney is a hardy organ. Normally it is constantly regenerating itself after each and every repeated damage. New renal cells grow back into the injured tubules and glomeruli, along with scar tissue which only after long years predominates over the regrowth of useful urine manufacturing cells. For years the defective kidney may give no symptoms, not even pain. On the contrary, a failing heart promptly notifies the patient, and a diseased lung strikes with alarming swiftness.

The kidney is a complex organ. Like the liver it has a number of inter-related but differing functions to perform. Some of these are but poorly understood. It is affected by exposure to cold, markedly disturbed by certain prolonged fevers, discharges albuminous urine after violent exercise or, in many, after nothing more than prolonged standing. It bravely eliminates many violent protoplasmic poisons; it is responsive to blood pressure changes; it maintains the proper concentration of salts in the fluids and tissues of the body; it aids in maintaining the acid-base equilibrium of the body by discharging acid corresponding in amount to from three to three and one-half grams of pure sulphuric acid per day; it removes from the body certain waste nitrogenous metabolites; it eliminates as creatinine certain wastes resulting from the continual destruction going on in the structural tissues of the body. Blood supply to the kidney is remarkable as it has been estimated that in normal health it is flushed with from 1000 to 1500 litres each twenty-four hours. Urine manufacture bears no constant relationship to food or fluid intake and the composition of urine varies, except in most advanced kidney diseases, from hour to hour. The actual control of the amount and composition of the urine is the chemical composition of the blood plasma circulating from moment to moment in the kidneys. No one test can therefore measure kidney function as a whole nor can the efficiency of the renal system be determined with the accuracy characteristic of heart studies. Clinical judgment and experience still enjoy a preeminent place in the interpretation of reports of the functional tests in the light of the appearance of the patient and the symptoms and history given by him.

Unless you know the cause of the patient's difficulty, be suspicious in case of extreme variation from the amount of urine normally passed; of polyuria or nocturia; urine specimens of persistently low specific gravities; vague gastro-intestinal disturbances especially if accompanied by nausea, vomiting or diarrhea; persistent or intractable headache; continued hypertension; edema; continual nervousness especially with peculiar twitching and starting movements or convulsive seizures; dyspnea and palpitation especially if periodic or nocturnal; retinal hemorrhages; or even so common a complaint as insomnia. Of course only certain of these patients will be found to be deficient in kidney function, but true nephropathies will be demonstrated in all these groups if the case series is extensive enough and the examiner is patient enough in his investigations.

Routine study is not always the best way to approach a problem; it may become dull and irksome. However, in order to find a way out of possible confusion, a charted course is often a most satisfactory way of attaining results. There is much waste of labor and incurring of expense in many kidney function routines, and yet there is no type of diagnostic practice requiring more search for both normal and abnormal response to testing. The routine now to be submitted has been deliberately made simple. It is intended only as a common-sense working system; it can be elaborated upon as much as the individual may desire; but it cannot well be curtailed. By following it the status of the kidney function of a patient may be learned within two to four days. All tests, except the last one, may be easily and accurately done by the doctor or his office attendant with a mini-

mum of time. The patient is but little disturbed by complexities or pain-producing procedures. The last procedure of the test, the determination of the blood urea nitrogen, may now be reasonably obtained for three or five dollars from practically all hospital or office laboratories.

The routine:

1. Cardiovascular examination: Done in the main to detect cardiac enlargement, edema, arteriosclerosis, cardiac decompensation. Cardiac cripples rarely escape renal difficulties.
2. Urinalysis of the 24 hour specimen: Test for albumen or proteins. Add to one-half inch of urine in a test tube a few drops of acetic acid and then add six or more drops of a saturated aqueous solution of salicylsulphonic acid. A dense white precipitate immediately forming is indicative of albumin and if none forms the specimen is free of albumin. This test is more sensitive and more easily performed than the usual tests.

   Test also for casts, pus, blood, and spermatozoa, by microscopic examination of the sediment of the specimen.

   Not all kidneys showing albuminuria and casts are seriously diseased but it will be conceded that the kidney manufacturing the urine is certainly damaged if only temporarily.
3. Urea Concentration Test: Restrict fluids sharply for 18 hours immediately prior to the morning of the test. On the morning of the test have the patient empty his bladder. Then give 15 grams of urea in 100 cc. of water using a few drops of tincture of orange to disguise the unpleasant metallic taste of the urea. Urea may be given safely even to a uremic patient. One hour after the urea is given collect a urine specimen and discard it. One hour after this specimen has been collected and discarded, (two hours after urea was taken), collect the urine specimen to be examined. This specimen should not amount to more than 120 cc. and by the simple hypobromite analysis should show the presence of two to two and one-half per cent urea for fairly efficient kidneys and up to three and one-half per cent or better for more excellent function. Note: Prolonged abstaining from fluid, persistent diarrhea, or long continued excess of protein intake or extrarenal pathologic conditions, notably, cardiac disease, acute or subacute intestinal obstruction, pneumonia, empyema, and prolonged fevers, increase the urine urea concentration in this test but if diminution in urea percentage occurs below two per cent, definite, renal deficiency is indicated. It will detect defective kidneys in chronic disease long before blood urea nitrogen will be increased.
4. Specific gravity test. This is about the simplest and at the same time the most reliable of all the renal function tests. It is often referred to as the concentration test. Supper at 6 p.m. the evening before the test. This meal is made rich in protein and the fluids limited to 200 cc. The patient then neither eats nor drinks anything until the test is completed. The bladder is emptied upon retiring and any night urine is discarded. On awakening the patient remains in bed and voids specimens at 8 a.m., 9 a.m. and 10 a.m., collecting the specimens in individual bottles labelled "8" and "9" and "10". Thus sixteen hours have been given the kidneys to concentrate with little inconvenience to the patient. Take the specific gravity of the three specimens. Interpretation: If kidney function is not impaired the specific gravity of at least one of the specimens will exceed 1024 often going to 1032. In severe renal impairment the maximum specific gravity is but 1010. With true uremia the maximum is under 1020 and oftener nearer 1010.

   In every patient exhibiting low specific gravity it is important to observe if edema is being evacuated, for this may simulate inability to concentrate.
5. The phenolsulphonphthalein test: Included in the routine with hesitation as it has been shown to be open to rather varying results and occasional grave errors. It is easily done and is perhaps, other than the simple urinalysis, the most universally done kidney function test. It is assumed therefore that it is universally known in its technic. Its chief usefulness seems to be in study of the kidneys individually by ureteral catheterization. This test may often be omitted in the routine, unless the kidneys are being studied individually for surgery upon the defective kidney in the pair.

6. The blood urea determination: 5 cc. of blood is shaken well in a tube containing a small amount of sodium oxalate. Thus coagulation does not occur. Refrigeration or other preservative is not required for the urea nitrogen determination up to at least 48 hours. The determination of blood urea is simple and practically fool proof in the average laboratory. The technic is not discussed as it is assumed that the physician usually has this test done for him.

These are the six steps in the routine. Several days are required for their completion. Upon their conclusion we may not know the exact diagnosis but we do know whether a damaged kidney is one of the villains in the play, and as the plot unravels the diagnosis will become evident. Renal insufficiency is a relative term. It is very true that with proper limitation of fluids, salt, and protein a patient even though a kidney casualty may be able to excrete completely the waste products from his body, when on a normal diet he would accumulate them in his system. Impairment of renal function is the first stage; the kidneys cannot manufacture urine of high concentration; usually for a time a compensatory polyuria will eliminate the waste adequately. Actual renal insufficiency is the second stage in impairment and in this state the waste products accumulate in the circulating blood because they do not find complete exit through the now severely diseased kidney.

Sign posts sighted at random in kidney observation: Color and sediment usually meaning much to the layman often may mean little to the experienced physician. Kidneys except in certain conditions rarely give pain. The pain-in-the-back scares of the patent medicine ads are ready bait for the gullible and ignorant. A urine boiling solid or semi-solid usually indicates uremia or eclampsia, but presence of albumin in the urine does not always mean nephritis. A lower than normal blood urea is usually present in the kidney failure of eclamptics. Renal failure occurring acutely after severe burns usually shows high blood urea nitrogens. Generally speaking, hyaline casts indicate least damage and waxy casts the most serious damage. Persistence of casts in large numbers regardless of type merit serious consideration. Renal cells and blood in the urine (if coming actually from the kidney and not from elsewhere in the urogenital tract often mean acute nephritis (or stone). A zero or extremely low phenolsulphonphthalein test is not usually compatible with long life nor is a blood creatinine remaining persistently above 5 mg. per 100 cc. of blood.

In surgery, especially prostatic, a urea nitrogen above 30 mg. per 100 cc. of blood is of serious import and no surgery except emergency procedures should be undertaken before the blood urea is brought to lower levels. The normal blood urea nitrogen is 15 mg.; the normal blood creatinine varies between 1 and 2 mg.; the normal phenolsuphonphthalein elimination in two hours is from 60 to 80%; the normal urea in the urine after 15 mg. of urea by month in the second hour specimen is 2-2½%; the normal daily 24 hour output of urine for men is 1500 to 2000 cc., for women 1000 to 1500 cc. and children half the amount of adults.

Conclusion

Internists are frequently called upon for a determination of a patient's cardiac reserve, for a differential diagnosis in a comatose state, for an investigation of surgical shock, for an examination of the lungs for suspected tuberculosis or pneumonia, or for a thorough going detective search for syphilis. Many times these invitations precede a major surgical operation or an impending danger in childbirth; follow serious accidental injury; precede selection of applicants for highly specialized employment such as the air service; or are made in connection with applications for large amounts of life insurance. Often they are made commendably in connection with routine periodic health examinations. People have become accustomed to these investigations and have learned to expect in these instances to have a thorough study and pay adequately for it. The same people are more complacent about their kidney function. You rarely hear a patient mention the fact that he has kidney disease unless he has first been so informed by a physician.

Unfortunately, the ordinary urinalysis, and a single random one at that, is too often the paramount issue and if normal report is given it is often to them tantamount to kidney health, nor are the patients to be criticised for their lack of knowledge. Their physician has been too complacent or lazy in watching their kidneys. Perhaps routine life in-

surance examinations have stressed too heavily the routine urinalysis. We are responsible to our patients for more practical study of kidneys and for more analyses of medical and surgical deaths for evidence of kidney defect. We should suspect disease of all kidneys until proved normal. Many kidneys will make a passing grade for many long years to come.

608 Greenleaf Bldg.

ACUTE POSTTRAUMATIC OSTEOPOROSIS*

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In calling your attention to acute posttraumatic osteoporosis or Sudeck's disease, I believe I am presenting a type of bone atrophy which is often overlooked or not recognized as such, and is very apt to be wrongly diagnosed. Perhaps all of you who are doing traumatic surgery can recall one or more cases of injured feet that seemed unusually slow in recovery from what appeared to be a trivial injury. After months of disability some cases may have cleared up and in others, the patients limped on beyond your horizon, and may still be limping. If the injury involved liability, you probably looked askance at the case and had compensationitis in your mind—especially since an x-ray immediately after injury was negative as to any bony pathology.

Atrophy following bed-confining illness, fractures or paralysis is of little consequence, gives no particular symptoms, except lessened density to the x-ray. Recovery is prompt and uneventful. However, occasionally a case of atrophy is encountered in which recovery is not prompt, which is painful and in which x-ray examination shows a patchy or moth-eaten appearance of the bones in the region of the injury. It is this type of atrophy that is disabling and the injured is accused of malingering. Surgeons not familiar with this condition may recommend drastic measures, e. g. amputation, for its treatment.

Sudeck first described this type of bone atrophy in 1900. Since then data have been accumulated with reference to symptomatology, pathology and treatment, but no adequate explanation of its etiology has been generally accepted.

Beck, a German orthopedic surgeon, classifies the etiological fractures of bone atrophy, in general, as follows: (1) atrophy due to deficient nutrition; (2) disuse atrophy; (3) acute reflex atrophy (Sudeck's); (4) neuropathic atrophy.

At the 1921 and 1928 Congress of the German Orthopedic Association, one of the main topics under consideration was the condition presented in this paper. In 1928 the subject was opened by Beck. He suggested that disturbance in the circulation, particularly in the sense of an increased capillary and venous pressure, results in a local accumulation of carbon dioxide, and stimulates osteoclastic absorption of the bone. He indicated that Sudeck's atrophy seems to be due to a collateral hyperemia. He stressed the importance of edema, cyanosis, and atrophy of the skin, changes which are always present in acute bone atrophy, as indicating a disturbance in circulation.

DIAGNOSIS AND CLINICAL COURSE

The clinical appearance of a case of acute posttraumatic osteoporosis is fairly typical within a few days after the reception of what is apparently a trivial injury: contusions, sprains, a scald or a simple fracture. The foot or hand which has been somewhat swollen and painful following the accident, becomes progressively more swollen and painful. The parts are tense and engorged with blood. One would suspect an abscess, but there is absence of fluctuation. The skin becomes smooth and glossy. The joints seem to be ankylosed and manipulation, active or passive, is extremely painful. If the foot is involved, the least pressure to the floor is unbearable. Absolute rest nearly always relieves the pain. The swelling is very persistant, which obliterates the skin markings. The tenseness and glossy appearance of the skin so resemble the presence of pus you may be tempted to aspirate or incise the affected part. This should not be done. The swelling can be reduced by prolonged elevation.

Roentgen examination made within a few weeks from the date of injury demonstrates patchy or moth-eaten appearance in the neighborhood of the injury as well as in the adjacent bones and joints. If the carpal bones are injured the atrophy may extend to the lower end of the radius. In shoulder joint in-

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juries the scapula and upper end of the humerus may show an osteoporosis.

Sudeck divided the progress of the disease into two stages: the acute and the chronic. The acute is the most important as it is more easily recognized and in this stage the disease responds more readily to conservative treatment. Other German authors divide the progress of the disease into three stages: the onset, the height of the disease and the reorganization. These three stages are plainly demonstrated by the x-ray. At the onset the typical patchy appearance of the bones is noted. At the height of the disease the irregular patchy areas disappear and the bones are more uniformly permeable to the x-ray. During the reconstruction period slow recalcification takes place. Fontaine and Hermann state that in most cases complete recalcification never takes place, but this does not prevent normal function.

It is in the second stage that a diagnosis of tuberculous osteoarthritis is likely to be made and radical measures taken. Clinical diagnosis is dependent upon the early patchy appearance of the bones as demonstrated in the x-ray examination, loss of function and pain all out of proportion to the type of accident received.

The important points in the pathology may be summed up in a few words: the patchy, moth-eaten appearance upon x-ray examination, very large haversian canals and a diminution of the number and thickness of the lamellae. There is no sequestra or periosteal thickening as in osteomyelitis. Skin and muscular atrophy are present.

SITE

The feet and hands are the most common site of osteoporosis. However, involvement of the shoulder, spine and skull have been reported. Mayos report a case involving the entire arm.

TREATMENT

The first step in treatment is convincing the patient that recovery will occur if weight-bearing is tried. Considerable urging is needed from time to time in order to get the patient to follow instructions. Oral medication such as cod liver oil and calcium lactate is of doubtful value. Due to extreme pain on weight-bearing some mechanical device is frequently necessary. Recovery from this condition is very slow. A clinical cure is likely to take from six months to one year, or even longer. The more walking, the quicker the recovery.

The method of treatment suggested and used by Dr. Frank B. Gurd of Montreal is the one I have followed.

In osteoporosis involving the wrist a snugly fitting plaster-of-Paris bandage should be applied.

In treating the foot the first and most necessary procedure is to elevate the leg to about a 45-degree angle, with the patient in bed for three days or more. This reduces the swelling completely. A silk stocking is then placed on the limb and a plaster-of-Paris bandage applied from toes to knee in cases of foot and ankle-joint lesions. The cast is made to cover the fourth and fifth toes and is molded snugly to fit the contours of the limb, and especially around the head of the tibia below the patella, thus allowing knee mobility. The heel and ankle should be reinforced. When the plaster is thoroughly dried a heel may be fitted and fastened with adhesive tape. With this support the patient can walk without crutches or cane. In six to eight weeks the cast may be removed and walking is attempted with a well fitted shoe. However, if this is impossible, another cast is applied. After removal of cast, massage and heat is used until good function has returned.

CASE REPORT

A railroad brakeman, aged 38, on May 1, 1935, received a contusion and laceration of the right foot. The laceration extended for about 2½ inches along the inner border of the foot, and was rather superficial in appearance. The contusion or laceration did not have the appearance of an injury that would cause a prolonged disability. An x-ray was taken of the foot and there was no evidence of bone injury. The laceration was not sutured and just the routine antiseptic dressings applied. The pain in the foot was severe and persistant, and, instead of lessening as would normally be expected, increased, until he was unable to bear any weight on his foot or keep it in a dependent position any length of time. The swelling, while not excessive, continued and the skin had a smooth, glossy appearance. As I had estimated his disability from 2 to 3 weeks, he asked permission to go to his home in Georgia during that time. I told him to report to his physician for dressings, which he did. His physician there also made some sim-

ilar estimation of the disability. However, at the end of three weeks he returned to Tampa, unimproved, although the laceration was nearly well.

It was at this time a second x-ray was taken, and a diagnosis was made by the roentgenologist of tuberculous osteoarthritis. I could not subscribe to this diagnosis, as I remembered an article by Frank B. Gurd of Montreal, describing an unusual type of atrophy following a trivial accident, which he called post-traumatic osteoporosis, and this case seemed to fit the description.

On reading his article again I found it fitted the case in question in all clinical and pathological details. The pain, swelling and x-ray findings were as described by him and treatment was instituted according to his methods. The patient's recovery was slow but progressive and he was able to return to work in December of the same year—8 months from date of injury.

Citizens Bank Bldg.

A STUDY OF THE BLOOD SEDIMENTATION TEST IN PULMONARY TUBERCULOSIS
(A Preliminary Report)

Arthur J. Logie, M. D.
Jacksonville

This study was made during the ten months that I was in charge of the Tuberculosis Department of the State Hospital at Chattahoochee. At the State Hospital it was a routine measure to determine the blood sedimentation rate on all patients admitted to the tuberculosis wards.

Although the sedimentation test has reached the foreground only within recent years it has a long history. Galen described the phenomenon and referred to it as the Crusta sanguinis. Hunter was the first to call attention to the parallel relationship between the speed of sedimentation and the severity of the disease present. Fahraeus introduced it as a routine laboratory procedure[1].

The blood sedimentation test consists in observing the rapidity with which the red blood corpuscles settle from the plasma. The sedimentation rate is not a special test for any disease but it appears to have some value in such diseases as rheumatic fever, certain gynecological conditions, and tuberculosis. Westergren states that the normal sedimentation rate is never seen in active tuberculosis. It is supposed that certain pathologic substances enter the blood which accelerate the sedimentation speed. The cause of the phenomenon is not clear. It is apparently connected with the ratio of albumin, globulin, and fibrinogen in the plasma, or with the concentration of cholesterol. Cutler states that as an aid in estimating activity the sedimentation test is more reliable than the temperature curve, pulse rate, or change in weight, the three major clinical guides in the prognosis of tuberculosis.

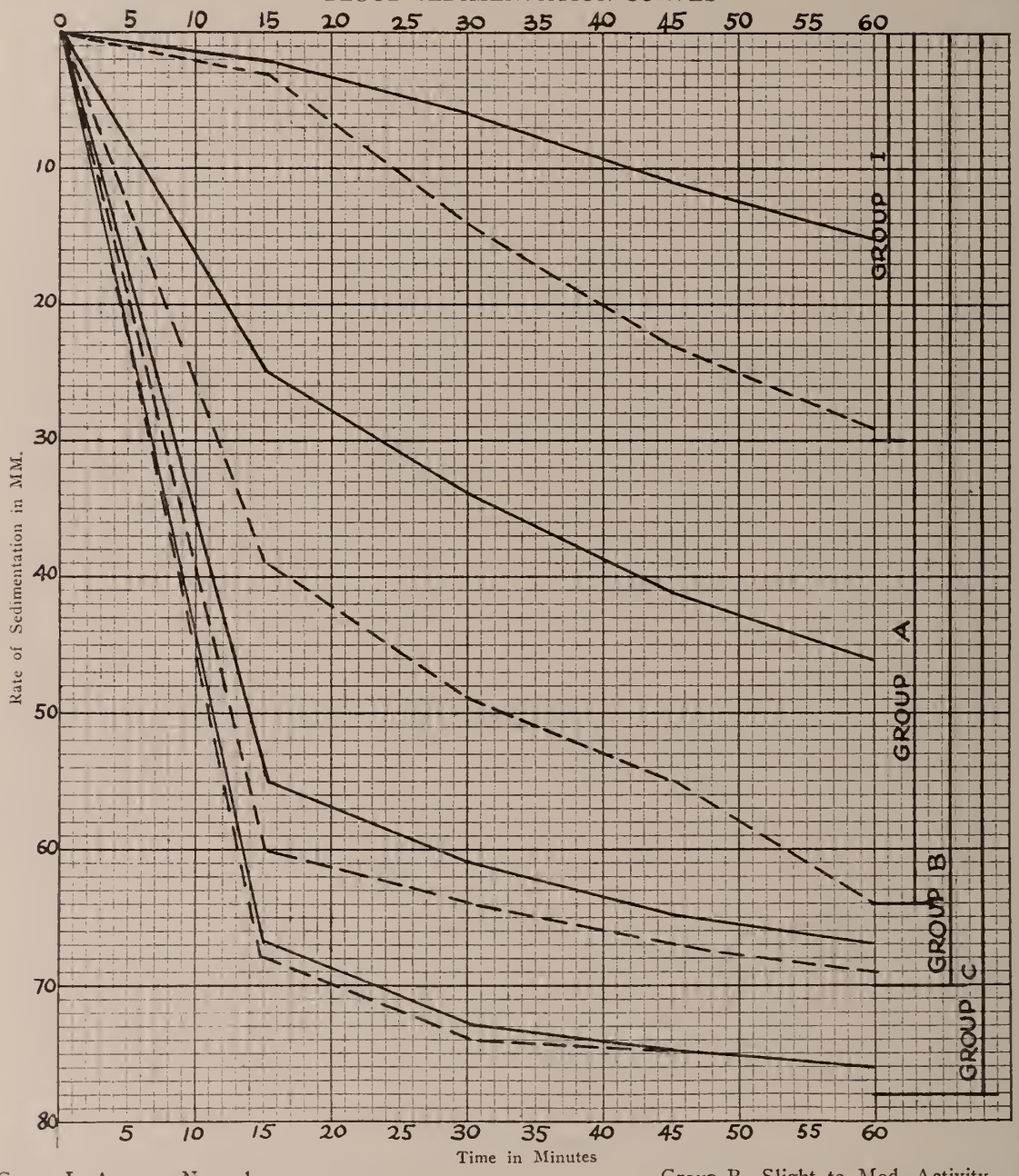
Still more information is obtained by making a series of observations and registering the changes in sedimentation rate. However, if a single normal sedimentation rate is found it points against pulmonary tuberculosis. It is stated that the sedimentation rate is the last sign to become normal, and when it does so, it denotes quiescence.

In our procedure we have observed the sedimentation at intervals of five minutes for one hour, but have traced the levels of the sedimenting column of erythrocytes, graphically, at fifteen-minute intervals. Various methods are in use, namely; the Westergren, Linzenmeier, and the Cutler. As we wished to limit the amount of work which would fall upon our laboratory department, and, as it was desired to use some method which would lessen the time element without detracting from the accuracy of the test, the simplified technique in the use of Brooks' micro-sedimentation pipettes attracted our attention.

The new Brooks' sedimentation pipette[2] is a graduated capillary tube with a bore 1 mm. in diameter having a fitting at one end for an intravenous needle and at the other end a stopcock exactly 100 mm. from the tip. The tube is first flushed with a 20% solution of potassium oxalate (anticoagulant) which forms a film on its inner surface. The needle is quickly inserted into the cubital vein and blood rises by its own pressure until it passes the stopcock which is immediately closed. In this manner a column of exactly 100 mm. of blood is obtained. The needle is then removed and the pipette is immediately inverted and placed in the upright position while the sedimentation can be observed. The rate is estimated by the depth of the clear fluid which appears at the upper end of the tube. According to reports, in tuberculosis, the severely ill

CHART I

BLOOD SEDIMENTATION CURVES



Group I—Average Normal.
Group A—App. Quiescent to Slight Activity.
Group B—Slight to Mod. Activity.
Group C—Moderate to Marked Activity.

CHART II

Time in Minutes

Sedimentation Change	X-Ray Change	Sputum Change
8 Decreased (indicating diminished activity)	4 Regressive	3 Reduced Gaffky Count
		1 Positive to Negative Conversion
	4 No Apparent Change	3 Positive to Negative Sputum but occas. pos. gastric contents
		1 Reduced Bacillary Content
7 Increased—3 died (indicating increased activity)	3 Progressive	All Increased Bacillary Content
	1 No Apparent Change	High Gaffky Count

cases show, within one hour, a maximum fall of the sedimenting column. Our own experience shows a very slight change of the sedimentation level after one hour.

In this study we are dealing with patients having pulmonary tuberculosis with some mental disorder. The majority of our subjects were diagnosed as dementia praecox cases, the others included a number diagnosed as manic depressive psychoses and twelve syphilitics with psychosis. In order to eliminate the possibility of false interpretations of those sedimentation rates which might be influenced by the mental disorder of these patients, we resorted to an intensive investigation of the literature on the subject.

Goldwyn[3] states that in mental diseases such as manic depressive psychoses, psychopathic personalities, and paranoia there is no change in the sedimentation velocity unless complicated by physical disease. Freeman[4] agrees; but adds that the degree of mental deterioration does not affect the sedimentation rate. Bower and Schein[5] believe that the test is the best means of following the progress of tuberculous activity in psychotic cases, especially if deteriorated.

In a study of over 2,500 sedimentation tests on psychotic patients at the Elgin State Hospital it was found that functional psychoses unless complicated by some physical disorder are characterized by normal sedimentation rates, and that the test along with the x-ray is the best means of following the progress of tuberculosis in psychotic patients, especially those of a deteriorated non-cooperative type.[6] We concluded from our study of the literature that the mental disorder of our patients had very little effect, if any, upon the sedimentation velocity.

As no normal standards were available, we thought it advisable to compute our own (Brooks' Method) for the purpose of comparison. Thirty-five healthy individuals ranging in age from twenty to fifty years were tested. Group 1 comprised the average curves of this group. In the male normal—fifteen adult males—the average fall of the sedimenting blood column within the first fifteen minutes was 2 mm. with a fairly gradual and steady decline to the 15 mm. level within the first hour. The female normal—twenty nonmenstruating—showed a decline to 3 mm. in the first fifteen minutes, reaching the 29 mm. mark in sixty minutes. The female curves are represented by dotted lines for each corresponding group. These types of curves differ considerably from the results obtained by the Cutler Graphic Method[7] in which the normal for males is a fall of the blood column from 2 to 8 mm. in one hour, and in females from 2 to 10 mm.

There were 58 patients admitted to the tuberculosis department from January to October 1936. Artificial pneumothorax was successfully induced in 25 of these cases. Fifty-three of these cases, 31 males and 22 females are the subjects of this study on whom 148 sedimentation tests were done. As the number of sedimentation rates is relatively small this publication is presented in the nature of a preliminary report.

On chart I, group A represents the apparently quiescent to slight activity group—35 sedimentation rates done on 15 cases. This group included those who over a period of six months showed few if any clinical signs of any active pulmonary lesion (rales, etc.), with stationary or regressive radiological findings, negative sputum or very occasionally positive results on concentrated examination of the sputum or gastric contents. In this group the male curve falls to 25 mm. within the first 15 minutes and to 46 mm. in one hour; the female to 39 mm. the first 15 minutes and to 64 mm. in the hour.

Group B (Chart I) represents the average curves of those cases in which there was slight to moderate activity—66 sedimentation rates on 20 cases. For the males, the curve falls to 55 mm. in the first 15 minutes and to 67 mm. in one hour, and for the females, to 60 mm. in 15 minutes and 69 mm. in one hour.

Group C (Chart I) represents those cases in which there was moderate to marked activity—47 sedimentation rates on 18 cases. The male curve falls to 67 mm. in 15 minutes and to 76 mm. in one hour, while the female curve declines to 68 mm. in 15 minutes and to 76 mm. in one hour.

These results enable us to classify the tuberculous cases according to activity. Using the Brooks' method, we are inclined to consider the first 15 minutes of the test (induction period) more significant than the type of curve over one hour of observation. As a

variable degree of anemia is present in the majority of tuberculous cases, and as the sedimentation rate is usually accelerated in anemia, we feel that a single sedimentation rate may establish a faulty criterion unless corrections be made by hematocrit estimations or the average of several rates taken at different intervals. If the blood sedimentation rate drops to 50 mm. within the first 15 minutes we place the patient on the Weak List, and if below 60 mm. on the Critical List. Our findings correspond with the reports of other investigators that in pulmonary tuberculosis the sedimentation speed of the blood increases with the activity of the disease. We find the blood sedimentation test of value in diagnosing a doubtful case of pulmonary tuberculosis, —but of far greater value, to the point where it may be relied upon, in the very important question of prognosis.

We have noticed that artificial pneumothorax decreases the sedimentation rate slightly, if not immediately after a refill. We believe that the diminished congestion brought about by the procedure is the underlying cause.[8] We have attempted to correlate the blood sedimentation rate with serial x-ray plates of the chest and sputum changes in a series of 15 tuberculous cases in which the sedimentation test had been repeated at intervals of three months. It is routine in this department to re-plate the chest every three months. The sputum was examined monthly, usually by smear and, when positive, reported according to the Gaffky count. We also did concentrated suptum examinations and examination of the gastric contents when indicated. This comparative study covers a period of nine months.

Of the fifteen selected cases eight patients showed gradually decreasing sedimentation rates (indicating diminishing activity of the disease), and seven had a gradually increasing fall of the blood column (increasing activity of lesion). All eight patients with decreasing sedimentation rates showed improvement in their general condition evidenced by the temperature curve, pulse rate, gain in weight and physical examination. Of these there were four with regressive radiological features (shown by serial chest plates), three which exhibited sputum with a reduced Gaffky count and one with a sputum conversion from positive to negative. The other four patients with decreasing rates had stationary x-ray lesions, three had positive gastric contents and one had sputum of a lowered bacillary content. (Chart II).

Of the seven cases with increasing sedimentation rates, three patients died, and four became clinically worse or remained unimproved. Of these four, three showed progressive radiological pathology while one showed no change. The sputum in each case exhibited a stationary or increased Gaffky count.

After a comparative study of the leukocytic index of these cases was made, it was evident that the sedimentation rate gave more reliable information as to the progress of the disease in the patient. This agrees with a recent study made by Muller.[9] Although I realize that more reliable information is obtained by evaluating all factors combined than by the consideration of a single factor alone, I am inclined to believe from these comparisons that the repeated blood sedimentation rate is of more value for information regarding the prognosis of pulmonary tuberculosis than any other single clinical finding.[10] I am satisfied with the simplicity and accuracy of the Brooks' method and recommend repeated blood sedimentation estimations as a routine procedure in the care of cases of pulmonary tuberculosis.[11]

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MEDICAL SOCIETY MEMBERSHIP

The importance of membership in the county medical society has been emphasized from time to time. Anything written in these columns, however, can be read by only the elect, so to speak, and those who should be reached are beyond the pale of the state medical Journal. For obvious reasons, the Journal is not read by them. It has become almost a truism that the physician is an individualist. Some carry this so far that they fail to mix with their professional confreres at all. It is a sociological fact that the individual can exist only as a member of a group. There is no such thing as rights which have not been secured for the individual by the group. This is true not only in the medical profession, but of mankind in the broadest sense. As Kipling has very tersely put it—

As the creeper that girdles the tree trunk,
the law runneth forward and back.
The strength of the pack is the wolf, and
the strength of the wolf is the pack.

In other words, in membership in a medical society only can one's individualism assert itself.

Membership in the medical society is an advantage not only to the member, but to the society. A characteristic of the professional association is that the main object is to improve the intellectual equipment of its members so that they may thereby render greater service to their patients or clients as the case may be. The economic phase, while no one will deny its importance, is always held in abeyance and is seldom discussed. The feeling is that the economic benefits will grow out of greater and higher qualities of service.

There has probably never been a time when membership in medical societies has not been important. Without a doubt such membership has always been worthwhile to the individual in one way or another. Possibly the motivating force in the organization of medical societies was the need for fellowship and stimulation afforded by meeting with one's colleagues. This need still exists. Medical science has advanced rapidly in the last two decades; it is continuing to advance. The individual physician would find it difficult indeed to keep pace with new developments if he relied entirely upon himself. However, through contact with his medical societies and through the postgraduate courses conducted by his state medical association, he is enabled to keep in touch with the times. He is kept informed of new advances in medicine and is encouraged in his desire to render his patients that superior type of service to which they are entitled.

The importance of this phase of the physician's life cannot be overemphasized. However, in addition to the need for education, the physician is confronted by economic problems which have multiplied greatly in the past few years. As an individual he is powerless to cope with them. He cannot even hope to be informed on all the various projects which would affect him in his daily life; much less can he hope to judge the merits or dangers of these projects. One man's vision is not enough; the viewpoint and judgment of many persons are necessary to determine the best course to pursue. Only by calm deliberation and careful weighing of the facts can the medical profession separate the wheat from the chaff. Only by working together can the physicians of this state map out the path they would follow.

It is possible that important changes will be made in the practice of medicine in the near future. If so, it is vitally essential for the medical profession to understand and initiate the changes through its own channels, rather than to have certain plans and schemes foisted upon it. The single individual is powerless to stem the tide, but by adding his strength to that of his fellow practitioners, he becomes a source of great potential strength. The Florida Medical Association is not a static force; it is a dynamic one. The number of its members grows from year to year. As long as the physicians in Florida bind themselves together, as long as they take an active part in the work of their organization, they will have the power to direct their own progress.

Dues for 1938 were payable January 1 of this year. Doctors who have not paid this year's dues have not received their 1938 membership cards. The secretary of your county medical society is also a busy practitioner. Why compel him to remind you continually of this obligation. A great proportion of our members pay their dues promptly and not only insure their status in organized medicine, but save the county societies and the State Association much unnecessary work. Members who have not paid this year's dues are urged to cooperate by immediately contacting the secretary of their county society and presenting him with $10.00 for 1938 state dues. It is to be hoped that all physicians will see the value of active participation in their medical organization and will cooperate in the present as they have in the past. When we take our places beside those whose interests and principles correspond to ours, we are helping to create a group, the demands of which cannot be denied. And in proportion, when ethical practitioners fail to take advantage of this opportunity they are weakening the structure of their own association which has been formed for the express purpose of bettering the conditions and maintaining the high standards of their chosen profession.

COUNTY MEDICAL SOCIETIES AND MEDICAL SERVICE

In the A. M. A. Journal of February 12, Volume 110, Number 7, page 77B, appears an outline which represents the first step in the study of medical needs under the auspices of the county medical societies which constitute the American Medical Association. This outline, prepared by the Bureau of Medical Economics of the American Medical Association, indicates the manner in which the study is to be made. Through the Bureau of Medical Economics a series of forms will be made available on which the results of the study are to be collated. These will then be forwarded to the headquarters of the American Medical Association for further analysis.

The medical picture changes from time to time with changing economic conditions. The situation in 1932, when the Committee on the Costs of Medical Care completed its studies, certainly differs from that in 1936-1937, when the United States Public Health Service made its survey of 750,000 families. As the county medical society is the chief unit in each county concerned with the care of the indigent and those able to pay only a part of medical costs, the county medical societies have been urged to assume leadership in coordinating the work of health agencies, welfare agencies and similar bodies. As soon as county medical societies become aware of the exact requirements, each may work out for itself the manner of meeting the needs. The state medical society as the policy-making unit will aid in determining the conditions under which service is to be administered. In certain areas several county medical societies may find it necessary to unite in order to meet conditions which naturally group themselves as a problem for several counties.

Obviously the next step will be the publication of information as to how the medical societies in this country are meeting the needs of their communities so that other counties similarly situated may take advantage of this experience. It is hoped, through the Bureau of Medical Economics and through the office of the Secretary of the American Medical Association, to maintain these activities at a steady and progressive pace. By the prompt

achievement of reasonable success in this nation-wide coordinated effort the American medical profession may again demonstrate its willingness and its ability to provide the people of this country with the best possible medical service.

SURVEY OF MEDICAL HISTORY AT ST. AUGUSTINE

Considerable progress has been made during the past year toward the development of a plan to restore St. Augustine, the first permanent settlement made in the lands now included in the United States. The project is sponsored by the National Committeee for the preservation and Restoration of Historic St. Augustine, the Chairman of which is Dr. John C. Merriam, President of the Carnegie Institution of Washington. The membership of this Committee includes many distinguished scientists and public men. The project is being carried out in cooperation with Carnegie Institution, and a research unit, which is directed by Dr. Verne E. Chatelain of the Staff of Carnegie Institution, is now making a survey of the history of the locality and preparing plans for the work of restoration.

A committee from the St. Johns County Medical Society is collaborating with the research unit directed by Dr. Chatelain in collecting and arranging data for the survey of the medical history. The members of the Committee for Medical History are, Dr. John Spencer, Chairman, Dr. Vernon A. Lockwood, and Dr. R. D. Harris. Search is being made for data which relate to the following phases of the medical history of the locality: the Indian concept of medicine at the time Menendez landed and founded St. Augustine; the effects upon the health of the Indians of contact with the colonists; the medical problems, methods, and facilities of the colonists during the first Spanish occupation, the English occupation, the second Spanish occupation, and during the period which followed the purchase of Florida by the United States.

Considerable data relative to the medical history of St. Augustine have been collected. The sites of early hospitals have been located, and it is quite certain that the first hospital built within the limits of what is now the United States was the hospital of Santa Barbara. This hospital was built by De Canzo, Spanish Colonial Governor of Florida, in about 1600. One of these early hospitals will no doubt be included in the buildings selected for restoration, and it is planned to utilize space in the restored hospital for a medical museum.

Physicians who are interested in the work of this Committee for Medical History are asked to communicate with Dr. John Spencer, 32 Saragossa Street, St. Augustine, Florida.

LEGISLATION RELATING TO LICENSES TO PRACTICE THE HEALING ART

A. Legislation with Respect to Corporate Practice

A law enacted in California specifically prohibits the corporate practice of medicine. A bill containing a similar prohibition was killed in Oklahoma.

Laws were enacted in California, Georgia, Maryland and Pennsylvania authorizing the formation of corporations to provide on a so-called "non-profit basis" "hospital care" to their members or subscribers. The activities of such corporations under these laws would seem to be limited to the rendition of hospital services and not to include medical or surgical care. Similar bills were killed in four other states.

Bills were considered and killed in six states which, if enacted, would have permitted unlicensed individuals, associations or corporations to contract to furnish, on an insurance basis, medicine, medical or surgical treatment, nursing, hospital service or dental service. The Washington senate killed a bill to create a commission to investigate the organization, operation and control of hospital associations, medical service bureaus and other organizations supplying medical, hospital or surgical care and to report its findings to the 1939 session of the legislature.

A. M. A. Journal of February 5, 1938, Volume 110, Number 6, page 59B.

Your membership dues of $10.00 were payable January 1. The secretary of your county medical society is a busy doctor. Why not give him your dues promptly?

DELEGATES AND ALTERNATES ELECTED BY COMPONENT SOCIETIES TO THE ANNUAL MEETING IN MIAMI, 1938

The number of delegates to be seated from any one component society will be one for each twenty members who have paid 1938 dues and one for each major fraction thereof.

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W. E. Murphree ..... Raiford

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STATE NEWS ITEMS

Dr. Henry Damon Smith, formerly of Sanford, is taking postgraduate work at Tulane University. At its completion, he will locate at Panama City, where his practice will be limited to O. L. A. R.

* * *

Dr. Fuad Hanna of Miami Beach has returned from Vienna, Austria, where he had an appointment as an assistant to Professor Hans Finsterer on the surgical staff of the Vienna General Hospital for four months.

There will be a meeting of the American Association for the Study of Neoplastic Diseases at Emory University, Atlanta, Georgia, April 14, 15 and 16, 1938. This meeting will be a study of neoplastic diseases and doctors interested in malignancies are cordially invited to attend. Take your microscope. There will be no registration fee. The meeting is sponsored by the Georgia pathologists. For additional information, communicate with Dr. A. J. Ayres, 111 Medical Arts Building, Atlanta, Georgia.

* * *

At a meeting of the Committee on Medical Postgraduate Course, held on February 20, it was decided to hold the next session of the Short Course at Daytona Beach, June 27, through July 2.

* * *

The annual meeting of the American Association for Thoracic Surgery will be held in Atlanta at the Biltmore Hotel, April 4, 5 and 6, 1938. This is the first time the Association has met in the South. All members of the medical profession are invited to attend the sessions at the Biltmore Hotel. For further information, communicate with the secretary, Dr. Richard H. Meade, Jr., of Philadelphia.

* * *

"Health Education" will be featured by the American Medical Association in their broadcasts for four weeks beginning March 30. The phases of this topic to be presented are:

March 30—A Fool for a Day. Fallacies and popular beliefs that are not true and that influence behavior in a manner detrimental to health.

April 6—Living with People. Elements of mental hygiene; getting along with people; adjustment to the environment.

April 13—It May Happen to You. Accidents in the home and on the highway and ways to avoid them.

April 20—Who Chooses Your Doctor? The characteristics of a reputable physician as distinguished from cults, quacks, fakers, faddists or exploiters.

These broadcasts are presented over the Red network of the National Broadcasting Company from 2 to 2:30 E. S. T.

* * *

Dr. and Mrs. K. C. Thomas of Miami announce the birth of a daughter, Dorothy Helen, on February 10 at the Jackson Memorial Hospital.

Dr. William H. Pickett, formerly director of the Pensacola and Escambia County Health Department, is now Director of the Pinellas County Health Department with offices in St. Petersburg and Clearwater.

* * *

Dr. Edward Jelks, of Jacksonville, president of the State Association, has returned from Baltimore where he attended the Biennial Surgical Alumni Meeting at Johns Hopkins Hospital on February 25 and 26. During this meeting, Dr. Jelks' class observed its 25th get-together.

* * *

Dr. Andrew G. Brown of Miami announces the removal of his offices to the First National Bank Building of that city.

* * *

Dr. Charles W. Folsom of Miami will spend three months this spring in Vienna, Austria, taking work in ophthalmology and otolaryngology.

* * *

Dr. and Mrs. J. R. Sory of West Palm Beach announce the birth of a son, James Robert Sory, Jr., on February 10, at the Good Samaritan Hospital.

* * *

An exceptionally interesting and instructive talk was given in Jacksonville by Dr. Hugh H. Young of the Johns Hopkins Hospital before a combined meeting of the Riverside and County Hospital Staffs in the library of the State Board of Health on Friday, February 18. The principal subject discussed was Hermaphrodism and Adrenal Virilism. Dr. Young recently reported the twenty-first case of true hermaphrodism. He showed a number of interesting photographs and diagrams showing the various locations of the two sets of sex organs in these individuals. In addition a number of cases of virilism in women due to tumor of the adrenal gland were discussed. This condition often leads to the belief that the individuals are male due to the pronounced development of the clitoris. Thorough investigation usually demonstrates their unisexual identity. An unusually clear motion picture in color was shown demonstrating the approach and removal of these adrenal tumors.

* * *

Dr. and Mrs. S. Marion Salley of Miami have returned from a short vacation on the West Coast.

Doctors Feaster and Bieker of St. Petersburg announce the removal of their offices to 166 Fourth Avenue, N. E.

* * *

The members of the Duval County Medical Society interested in ophthalmology invited Dr. James W. White of New York to lecture on "Ocular Muscles" on February 5 and 6. Physicians specializing in ophthalmology over the State were invited to attend these meetings which were held in the office of Dr. Shaler Richardson. In addition to the lectures, the visiting doctors were entertained at a cocktail party on the evening of the 5th and at luncheon at Ponte Vedra on the following day.

The ophthalmologists of Jacksonville have for several years been hosts to an annual instructional gathering of this kind.

* * *

Dr. Robert M. Baker of Jacksonville and Miss Claire Henderson of Tampa were married on December 15, 1937.

LEONIDAS MOSBY ANDERSON

Dr. L. M. Anderson, past president and Life Member of the Florida Medical Association, died at his home in Lake City on January 21, at the age of 76.

Born in Missouri, Doctor Anderson secured his preliminary education in that State and later attended the Atlanta Medical College, now Emory University, from which he graduated in 1895. At the age of 23 he came to Florida to make his home. He located first at Lake Butler and then at White Springs, later transferring his practice to Jasper where he resided several years. In about 1908, he moved to Lake City where he took an active interest in civic affairs. He served that city on the Board of Aldermen and was a charter president of the Chamber of Commerce in the era when Columbia County was interested in building important highways. He was the second president of the local Rotary Club, the first to serve a full term. The Rotary Club later made him an honorary life member. He was instrumental, with others, in securing and retaining the United States Veterans Facility in his home city. The American Legion awarded Doctor Anderson its medal for distinguished service and citizenship in 1933.

The Florida Medical Association has lost one of its most active members. It is believed that few, if any, members of the Association have attended as many meetings and have served on as many committees as Doctor Anderson. He became a member of the Association in April, 1897, at an annual meeting in Palatka. In 1922, at a convention held in Havana, Cuba, he was elected president; in 1934 he became the organization's first Life Member. He served as Chairman of the Executive Committee and the Scientific Program Committee and, at different times, as a member of most of the other committees. He was for years president of the Columbia County Medical Society and he became the first Honorary Member from Florida of the Southern Medical Association in 1937. He was a past president of the Emory Medical Alumni in Florida and is believed to have been the oldest medical alumnus of that University in this State.

Dr. Anderson was appointed by Governor Cone as Inspector of State Institutions and Administration Advisor of the State Board of Health in May, 1937, which position he held until a few months before his death.

In the late '90's, Doctor Anderson and Miss Grace Gray of Abingdon, Va., were married. Mrs. Anderson, one son, Emmett Anderson of Tampa, and a daughter, Mrs. Russell Hackney of Lake City, survive him.

ADOLPH BERNARD QUASSER

Dr. Adolph B. Quasser of Jacksonville, died at his home on February 3, 1938, at the age of 41.

Doctor Quasser was born at Liban, Latvia, June 19, 1896, coming to the United States with his parents when a small boy. He attended the public schools of Portsmouth, Ohio, and received his pre-medical training at the University of Cincinnati. He was graduated from the Harvard Medical School in the class of 1922 with high scholastic honors. His internship was served in the Jewish Hospital at Cincinnati, where he trained under Dr. Samuel Igipur, after which he practiced medicine in his home town of Portsmouth.

Doctor Quasser took postgraduate work at the Polyclinic Hospital in New York City and the Harvard Medical School, specializing in diagnosis.

He was a member of the staff of Portsmouth General Hospital and Mercy Hospital

of that city, a member of the Hempstead Medical Academy of Portsmouth, chief examiner of the Forty and Eight Society of the American Legion and active in the Junior Chamber of Commerce, the Portsmouth Country Club and other civic and social organizations in Porstmouth.

Doctor Quasser moved to Jacksonville in 1930 and practiced until he became ill several months ago. He was a member of the Duval County Medical Society, the Southeastern Urological Association, the Florida Medical Association, the American Medical Association, the Harvard Club of Cincinnati and the local voiture of the Forty and Eight Society.

In 1926 Doctor Quasser was married to Miss May Bird Cowart of Savannah, Ga., who survives him. Other survivors are his mother, Mrs. I. Quasser, and a sister, Mrs. Leonard Levin of Lorain, Ohio.

JOHN FRANKLIN WILLIAMS

Dr. John Franklin Williams of Monticello died in a Jacksonville hospital on February 6 after an illness of two weeks.

Born in Monroe County, West Virginia, January 1, 1866, he attended the Augusta Military College. After completing his studies, he moved to Florida, locating in Levy County and teaching for several years in the schools of that county. In 1893, he enrolled in the Atlanta College of Physicians and Surgeons and was graduated with honors in 1897. He returned to Florida and practiced his profession in Jefferson County until 1899 when he took a postgraduate course in the New York Polyclinic Medical School.

On July 5, 1899, he was married to Miss Mary Elizabeth Bearden of Milledgeville, Ga. Since 1901 he has made his home in Monticello.

Although he never sought political or fraternal preferments, Doctor Williams served as a member of the State Board of Medical Examiners, as president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, as Surgeon for the A. C. L. Railway and for eight years was president of the Jefferson County Board of Public Instruction. For many years he was an active member of the Presbyterian Church. He was a member of his county medical society, the Florida Medical Association and the American Medical Association.

Doctor Williams is survived by his widow, one daughter, Mrs. Lionel T. Starbird of Apopka, and four sons, J. F. Williams, Jr., and George B. Williams of Tallahassee, Dr. E. G. Williams of Lexington, Ky., and Kenneth Williams of Chicago, as well as several grandchildren.

In the passing of Doctor Williams, Monticello and Jefferson County have lost an outstanding citizen. His unselfish devotion to the sick and needy, his gentle and kindly understanding, endeared him to all whose lives were touched by his.

"Step softly, Soldier, o'er this sombre ground,
This hallowed tomb.
Haunted with the breath of flowers—evening showers,
God's Heavenly Blooms.
Pause ye in meditation on this life, its sorrows, strife,
Yield ye the Soldier's Last Salute,
In Memory of John Franklin Williams, Physician,
Friend of Man,
Whose voice in Death is Mute. (Amen.)"

(A tribute by a World War Veteran, Monticello, Florida)

Dr. Paul Eaton of Jacksonville, former Director of the State Board of Health Laboratory, died on February 25, after an extended illness.

* * *

Dr. B. Auxford Burks of Winter Park, died on February 24, at a sanitarium in Orlando, following an illness of a year.

* * *

Dr. Floyd Hamilton Randall, formerly of Boca Raton, died at Van Wert, Ohio, on September 16, 1937, at the age of 62. He was a member of the Palm Beach County Medical Society.

Dr. Randall graduated in 1899 from the University of Michigan, Department of Medicine and Surgery. He was a veteran of the World War.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

The regular meeting of the Dade County Medical Society was held on the evening of February 1 in the Assembly room of the Florida Power & Light Building. Dr. Arthur H. Weiland, president, presided.

Dr. James H. Mendel of Miami presented an exhibit discussion on "Ear Drums." Dr. Samuel G. Gant of New York City gave an interesting talk on "Diseases of the Rectum and Colon."

The following applications for membership were read and the applicants elected to membership: Dr. William H. Kupper of Miami Springs, and Dr. Efton J. Thomas of Miami.

* * *

DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society held its regular monthly meeting on the evening of March 1, in the State Board of Health Building. The following papers constituted the scientific program:

"Differential Diagnosis of Painless Jaundice"—Stanley Erwin;

"Indications for Surgery in Gall Bladder Disease"—Frederick J. Waas.

Drs. Gordon H. Ira, George W. Croft, Kenneth Morris and Edward Jelks opened the discussion.

* * *

JACKSON COUNTY MEDICAL SOCIETY

The Jackson County Medical Society held its regular meeting on February 8 in the Clubroom of the Chipola Hotel, Marianna. Dr. Rudolph Bell of Thomasville, Ga., was guest speaker and presented a paper on "When to Operate for Urinary Calculi."

The new officers of the Society are: President, D. A. McKinnon, Marianna; Vice-President, J. G. Gainey, Blountstown; Sec'y.-Treas., R. N. Joyner, Marianna; Delegate to State Convention, Lewis Pierce; Alternate Delegate, C. D. Whitaker.

* * *

LEE COUNTY MEDICAL SOCIETY

Officers were recently elected by the Lee County Medical Society to serve for 1938, as follows: President, H. Quillian Jones; Vice-President, B. Whisnant; Sec'y.-Treas., Harvie J. Stipe; Delegate to State Convention, H. J. Stipe; Alternate Delegate, Ernest Bostelman.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. William Haywood Walters of Lacoochee was host to the Pasco-Hernando-Citrus County Medical Society on Thursday evening, February 10. A quail dinner was enjoyed after which a scientific session was held. Dr. J. T. Bradshaw of San Antonio reported three cases of asthma treated with adrenilid chloride with severe reactions in each case. Dr. W. Wardlaw Jones of Dade City reported a case of hemorrhage in the uterus due to placenta separation.

Dr. J. T. Bradshaw of Dade City invited the members of the Society to be his guests on March 10.

* * *

PINELLAS COUNTY MEDICAL SOCIETY

At the semi-monthly dinner meeting of the Pinellas County Medical Society held at the Shrine Club on February 4, the scientific program was as follows:

Dr. W. E. Quicksall demonstrated a novel syringe attachment for irrigating small orifices. Dr. Harrison G. Palmer spoke of treating high blood pressure with diathermy. Dr. A. R. Frederick read an interesting and instructive paper on "Blood Pressure."

At a meeting of the Society held February 18, the following Delegates and Alternates were elected to represent the Society at the next annual meeting of the State Association: Delegates: William M. Davis, A. J. Wood, J. A. Strickland, W. C. McConnell. Alternates: O. O. Feaster, R. H. Knowlton, Prescott LeBreton, H. E. Winchester.

J. H. Shaw, D. D. S., guest speaker, reported a case of jaw infection with much cellulitis in which Vincent's infection predominated, following extraction of one tooth from an apparently healthy mouth. Dr. Reid E. Dicks reported a severe burn of a hand following short circuiting of a light socket. Dr. Prescott LeBreton spoke on "Spiking Hip Fractures" and Doctor Feaster presented x-ray plates of cases.

* * *

POLK COUNTY MEDICAL SOCIETY

At a recent meeting of the Polk County Medical Society, the following delegates and alternates were elected to represent the Society at the next annual meeting of the

State Association: Delegates, Dr. George Carefoot, Ft. Meade; Dr. J. R. Boulware, Lakeland; Dr. J. L. Hargrove, Bartow. Alternate Delegates, B. J. Bond, Winter Haven; R. L. Cline, Lakeland; R. L. Mooty, Winter Haven.

* * *

PUTNAM COUNTY MEDICAL SOCIETY

The Putnam County Medical Society met at the Marion Hotel, Palatka, Tuesday, February 8 for election of officers and general discussion. The election of officers resulted as follows: President, Z. Brantley, Grandin; Sec'y.-Treas., Allen P. Gurganious, Palatka. These two doctors have also been chosen to serve as delegate and alternate, respectively, at the next annual meeting of the State Association.

* * *

SEMINOLE COUNTY MEDICAL SOCIETY

THE SEMINOLE COUNTY MEDICAL SOCIETY STANDS 100% PAID FOR 1938. THIS SOCIETY IS THE SECOND THIS YEAR TO REACH THE HONOR ROLL. WITH A MEMBERSHIP OF THIRTEEN, THIS SOCIETY IS HEADED BY: PRESIDENT, J. N. TOLAR, SANFORD; VICE-PRES., THOS. F. McDANIEL, SANFORD; SEC'Y.-TREAS., D. G. SCOTT, SANFORD. CONGRATULATIONS, SEMINOLE COUNTY MEDICAL SOCIETY.

* * *

SUMTER COUNTY MEDICAL SOCIETY

At a recent meeting of the Sumter County Medical Society, the following officers were elected: President, C. L. Carter, Wildwood; Secretary, W. E. Mitchell, Bushnell. Dr. W. E. Mitchell was chosen to represent the Society as delegate at the next annual convention of the Florida Medical Association.

* * *

WALTON-OKALOOSA COUNTY MEDICAL SOCIETY

CONGRATULATIONS GO TO THE WALTON-OKALOOSA COUNTY MEDICAL SOCIETY ON BEING THE FIRST SOCIETY TO REPORT 100% DUES PAID FOR 1938. THIS SOCIETY IS THIS YEAR HEADED BY: PRESIDENT, A. B. WILLIAMS, LAKEWOOD; SEC'Y.-TREAS., R. B. SPIRES, DEFUNIAK SPRINGS.

ABSTRACT DEPARTMENT

Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.

Use of Unpadded Plaster in Treatment of Fractures—MABRY, CHARLES B., Jacksonville, *Am. J. Surg.*, 36:292-297 (April) 1937.

Mabry has used unpadded plaster as a method of fracture fixation for years and believes that his patients are ambulatory and mobile while the well padded patients are still in bed. Improved technique in application has lessened the fear of ischemic myositis which for many years nullified the use of this method.

Many advantages are cited by the author. The plaster applied directly on the skin, without previous preparation, molds closely over all bony prominences, producing much better fixation. Sweat and excretory oils are immediately absorbed by the plaster and are not left on the skin to produce future irritation. Because of better fixation, nearby joints can be exercised. On removal of walking casts applied in this manner, the joints are freely mobile immediately. The casts are removed easily and painlessly.

A New Type Portable Sterilizer for Syringes and Needles—MCSHANE, JAMES K., Miami, *J.A.M.A.* 108:1606 (May 8), 1937.

A very useful and compact portable sterilizer is described. It is a metal cylindrical tube six and one-half inches long, two and a quarter inches in diameter, weighing nine ounces. The base contains an electric unit which can be connected to either alternating or direct current. It requires water in the sterilizer to complete the circuit. The top is a friction cap containing a spring steam valve to allow the escape of steam. Inside is a removable holder for the syringes and needles. After placing water in the container, it boils in about a minute, and boils dry in about twenty minutes when the container can be put in one's bag with all syringes and needles sterile inside.

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BOOKS RECEIVED

Acknowledgment of books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.

THE PHYSICIAN'S BUSINESS. By GEORGE D. WOLF, M.D., Attending Otolaryngologist, Syndenham Hospital and Riverside Hospital, New York. A book devoted to the business end of the practice of medicine which no physician can escape. It deals very comprehensively with such topics as Hospital Internship, Medical Careers Other than Private Practice, Specialization, Location, Professional Contacts, the Doctor and his Patient, Planning and Equipping an Office, Office Personnel, Technics, Surgical Instruments, Forensic Medicine, Income Tax, Insurance, Current Trends in Medical Practice. Illustrated. Cloth. Price, $5.00. Pp. 384. J. B. Lippincott Company, Philadelphia.

HANDBOOK ON NASAL ACCESSORY SINUSES. By FRANK L. ALLOWAY, B.Sc., M.D., Kingsport, Tenn., formerly Chief, Dept. of Otolaryngology, U. S. Diagnostic Clinic, Wash. D. C. The author states that the purpose of the book is "to set forth in simple and concise form some of the basic principles of nasal accessory sinusitis," hoping that "the gathering of this knowledge from many sources into one compact volume will be of help to the busy otolaryngologist." This information is presented under the following captions: Anatomy of Nasal Accessory Sinuses, Symptoms of Sinusitis, Pathology, Diagnosis, Treatment, The Sinuses vs Eye Disorders, Osteomyelitis of the Skull, Chiasmal Tumor in Relation to Sinuses. Cloth. Pp. 120. J. B. Lippincott Company, Philadelphia.

MALNUTRITION, THE MEDICAL OCTOPUS. By JOHN PRESTON SUTHERLAND, M.D., Sc.D., Dean Emeritus of Boston University School of Medicine. A comprehensive volume, written in a simple, understandable way. Among the many subjects treated may be mentioned "Prenatal Life"; "Is Milk a Perfect Food?"; "Weaning and its Perils"; "Why the Modern Mother Cannot Nurse Her Children"; "Dentition, Normal and Defective"; "The Injurious Possibilities of Pure Food"; "Tuberculosis in Cattle, a Lesson for Mankind"; "The Unlearned Lesson of Beri-beri"; "A Few Thoughts on Vitamins"; "The Sugar Problem"; "The Meatless Diet"; "Constipation and its Curative Treatment"; "Man's Chief Dietetic Transgressions"; "The Prevention of Cancer"; all practical and vital subjects. Cloth. Price $3.00. Pp. 368. Meador Publishing Company, Boston.

THE COMPLEAT PEDIATRICIAN (Second, Completely Rewritten, 1938 Edition). By WILBURT C. DAVISON, M.A., D.Sc., M.D., Professor of Pediatrics, Duke University School of Medicine; Formerly Acting Pediatrician in Charge, The Johns Hopkins Hospital. Includes the Advances from 7,500 recent references, and new chapters on Growth, Development, Nutrition and Infant Mortality, and Contains: 1. Diagnosis. The 164 pediatric symptoms and signs with the diseases which cause them. 2. Diseases. Complete symptomatology, differential diagnosis, incidence and prognosis of 329 diseases of children. 3. Treatment, Fluid and Blood Administration. 4. Feeding, Diets and Nutrition. 5. Drugs and Prescriptions. Dosage of every useful remedy. 6. Laboratory Tests. 213 of the best practical methods described. 7. Preventive Measures and Child Care. How to eliminate many of the conditions which annually kill 240,000 American children. 8. Growth, Development

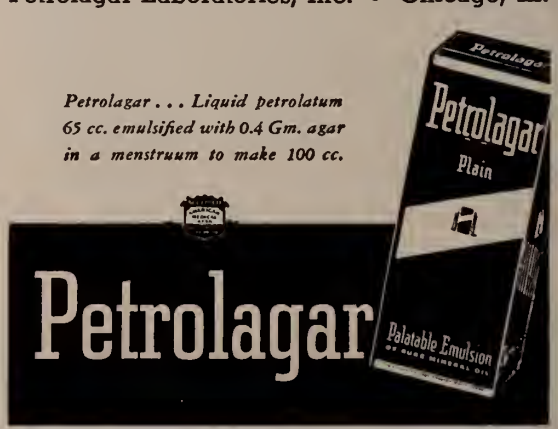


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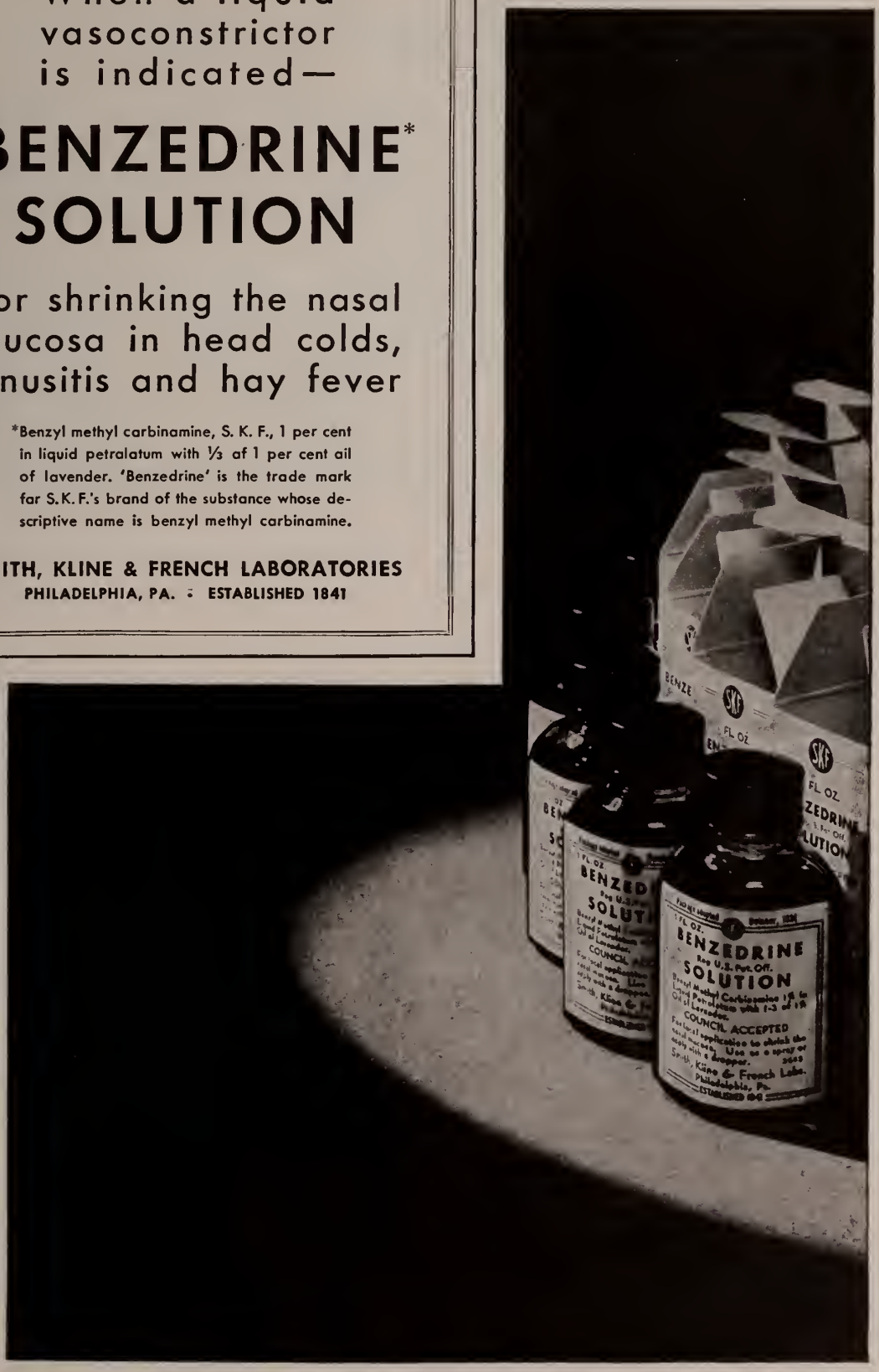
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and Guidance of Children. 9. Instructions for Taking Histories and Making Physical Examinations. Cloth. Price $3.75. Pp. 278. Duke University Press, Durham, N. C.

PHYSICIANS' VITAMIN REFERENCE BOOK. By the Medical Division, Professional Service Department, E. R. Squibb & Sons. A refreshing departure from the usual pharmaceutical manufacturers' effusions, on the overly-discussed subject of vitamins. The book is divided into several sections, seven describing from the clinical viewpoint the requirements and deficiency manifestations of Vitamins A, B_1, G Complex, B_2, C, D, and E. Another section deals with multiple deficiencies and there is a list of other vitamin-like factors. The subject matter appears to have been carefully selected and conservatively presented, and it repeatedly reproduces the attitude of the Council on Pharmacy and Chemistry toward the clinical use of the vitamins in certain pathological states. With a frankness that is commendable, negative reports are cited without bias, leaving, as should be done, the choice of therapy strictly with the physician. Any physician who is interested need only write to the firm to obtain a copy.

ADVERTISERS' NOTES

PROTAMINE ZINC INSULIN SQUIBB

Physicians will be interested to know that Protamine Zinc Insulin Squibb is now available in two strengths, 10 cc. vials of 40 units per cc. and 10 cc. vials of 80 units per cc.

Protamine Zinc Insulin has been available in the 40-unit strength since February 1, 1937. It was felt, however, that a higher potency was also needed for the many diabetics who require large amounts of Insulin daily.

While the efficiency of the two strengths of Protamine Zinc Insulin may be identical, the transfer of a patient from one strength to the other should be made only under the careful supervision of a physician until more experience has been accumulated.

Protamine Zinc Insulin Squibb is marketed under license from the Insulin Committee, University of Toronto.

NO-SCRU DEMONSTRATOR

To demonstrate how No-Scru and Tri-Flex combine to make the perfect rimless mounting, American Optical Company recently developed a No-Scru demonstrator which has been exceptionally well received.

This ingenious device is an enlarged model of the No-Scru pin, tube and the Tri-Flex strap, mounted on a glass-like block. It can be completely disassembled and again reassembled, showing exactly how the pin and the tube hold the strap in place on the lens, how the flutes or slots provide an escape for gases and thus facilitate an immediate flow of solder, and how Tri-Flex springs protect the lens and maintain adjustment.

The AO Fitting plate was also developed for users of No-Scru to facilitate rimless mounting. With the glove fit achieved by the use of the plate, plus the soldered pin and tube, a strap connection is formed which is perfect in every way.

Your American Optical Company representative will be glad to show you these two devices, and explain them in further detail.

RECENT STATEMENT BY THE JUDGES OF THE MEAD JOHNSON VITAMIN A AWARD

"The Vitamin A Award offered by Mead Johnson & Company was supposed to be made on the basis of papers published or accepted for publication by December 31, 1936. The judges of this award, meeting in New York, June 4, 1937, feel that its presentation at this time is not warranted since no clinical investi-

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gation on vitamin A has yet been published which completely answers any of the objectives of the original proposal. The judges, therefore, agreed to defer further consideration of the granting of this award until December 31, 1939. This action was taken because of the existence of pronounced differences of opinion among investigators as to the reliability of any method yet proposed for determining the actual vitamin A requirements."

STATEMENT BY
MEAD JOHNSON & COMPANY

In view of this action by the judges of the Mead Johnson Vitamin A Award, and as an earnest of our good faith in the matter, we have segregated from our corporate funds on deposit with the Continental Illinois National Bank & Trust Company of Chicago, the sum of $15,000. This cash deposit has been placed in escrow and will be paid promptly when the board of judges decides on the recipient of the Main or Clinical Award. The Laboratory Award of $5,000 was made on April 10th, 1935.

The Sixty-Fifth Annual Meeting
of the
FLORIDA MEDICAL ASSOCIATION
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TO THE

FLORIDA MEDICAL ASSOCIATION, INC.

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A Letter to the County Chairmen from Mrs. W. H. Spiers, in Charge of Program:

Let me call your attention to the Charge sent out by Dr. Edward Jelks, President of the Florida Medical Association. I would suggest that you have this Charge read at your next meeting.

Every Wednesday, from 2 to 2:30 p. m. Eastern Standard Time, the American Medical Association and the National Broadcasting Company present a program of dramatized health messages intended to furnish graphic supplementary material for health teaching in Junior and Senior High Schools. Let me urge you to place one of these Radio Programs with the Health Department of each school and the P.-T. A. Program Chairman, and stress the importance of these broadcasts. If there is no radio in the school, see if one can be secured for this broadcast.

Let me stress, too, the importance of a Health Institute in your county some time during the year. Appoint an active committee and have the very best speakers possible, and see that it is *well advertised.*

* * *

In Orange County, we are planning a Health Institute with speakers on tuberculosis, cancer, syphilis, pharmacy, dentistry, etc.

If I can be of any help to you in any of your projects, do call on me.

* * *

PINELLAS COUNTY

A luncheon meeting of the Auxiliary to the Pinellas County Medical Society was held at the Yacht Club in January. Officers and committee chairmen summarized the work accomplished during the past year.

Mrs. Franklin W. Roush, president, announced that the Auxiliary had become a

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Fractures and Traumatic Surgery—Informal Practical Course; Ten Day Intensive Course starting April 11th.

Otolaryngology—Two Weeks Intensive Course starting April 4th.

Ophthalmology—Two Weeks Intensive Course starting April 18th; Personal Course in Refraction.

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**Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245*
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245 ☐ Laryngoscope, 1935, XLV, 149 154 ☐
N. Y. State Jour. Med., 1935, 35, No. 11, 590 ☐ Laryngoscope, 1937, XLVII, 58-60 ☐

SIGNED:_____M. D.
(Please write name plainly)

ADDRESS_____

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FLO

member of the Mothers' Health Clinic. A motion was made to have an annual Doctor's Day included in the by-laws. This year, the Doctor's Day celebration will be arranged by Mrs. Alvin Mills, Mrs. A. R. Frederick, Mrs. J. A. Strickland, Mrs. A. S. Anderson, Mrs. Clyde O. Anderson and Mrs. O. O. Feaster.

Plans for the entertainment of visitors during the A. C. L. Convention in April are in charge of Mrs. J. A. Strickland and Mrs. L. M. Gable.

An amusing contest was enjoyed preceding the business session.

Members of the Auxiliary were hostesses at a tea at the Florence Crittenton Home when many donations for the Home were accepted. In the receiving line were Mrs. W. Glenn Post, Jr., and Mrs. Franklin W. Roush of the Auxiliary, and Mrs. Walter Calley and Mrs. William Treffeisen of the Home board. Mrs. William Farber and Mrs. A. J. Bieker assisted in serving and Mrs. Charles Hebard and Mrs. Mitchell Moran poured.

* * *

In loving memory of Mrs. William Lassiter, of Gainesville, the following Resolutions have been drawn. She was a guiding spirit in the organization of our State Auxiliary and at the time of her death was the beloved president of the Alachua County Auxiliary.

* * *

Anna Beers Lassiter
Past President

Death visited us and called Anna Beers Lassiter, wife of Dr. William Lassiter of Gainesville, January 13, 1938.

Whereas; Anna B. Lassiter was one of the four organizers of the Woman's Auxiliary to the Florida Medical Association, and was our first president,

Whereas; a loving mother, a faithful wife, and an indefatigable worker in our ranks has gone to her reward, whose place will be vacant, but whose memory will be an ever-present inspiration to the workers of our organization,

Therefore, Be It Resolved, that we adopt these resolutions, and that a copy be spread on our book of minutes, and that the secretary be instructed to present a copy to the bereaved family.

Flora P. (Mrs. G. C.) Tillman
Chairman.
Clara G. (Mrs. E. W.) Veal
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STATE AND SECTIONAL MEETINGS

SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Edward Jelks, Jacksonville	Shaler Richardson, Jacksonville	Miami, May 9-11, 1938
Florida Medical Districts:			
A—Northwest	J. S. Turberville, Century	Stewart Thompson, Jacksonville	Panama City, July 14, 1938
B—North Central	A. B. Albritton, Wildwood	" " "	Gainesville, Oct. 27, 1938
C—Northeast	Hugh West, DeLand	" " "	Ponte Vedra, Sept. 15, 1938
D—Southwest	J. A. Simmons, Arcadia	" " "	Bradenton, Sept. 29, 1938
E—South Central	W. C. Page, Cocoa	" " "	Leesburg, Nov. 10, 1938
F—Southeast	F. K. Herpel, West Palm Beach	" " "	Ft. Lauderdale, October 13,
Alabama Medical Association	E. S. Sledge, Mobile	D. L. Cannon, Montgomery	Mobile, April 19-21, 1938
Georgia Medical Association	George A. Traylor, Augusta	E. D. Shanks, Atlanta	Augusta, April 26-29, 1938
Am. Urol. Assn. (Southeastern Br.)	George Livermore, Memphis	Raymond Thompson, Charlotte, N. C.	Louisville, Dec. 2, 3, 1938
Florida—			
State Dental Association	R. D. Cummins, St. Petersburg	Lloyd Harlow, Bradenton	Jacksonville, 1938
Soc. of Derm and Syph.	C. A. Andrews, Tampa	Lauren Sompayrac, Jacksonville	Miami, May 9, 1938
East Coast Medical Association	Walter C. Jones, Miami	T. C. Kenaston, Cocoa	Melbourne, 1938
State Hospital Association	Mr. T. S. Alexander, Tampa	Mr. Fred Walker, Jacksonville	Birmingham, April 7-9, 1938
Medical Postgraduate Course	Turner Z. Cason, Jacksonville,	Chairman	Daytona Beach, June 27-Jul
Midland Medical Society	W. C. McConnell, St. Petersburg	B. H. Sanchez, Plant City	Orlando, April 28, 1938
State Nurses Association	Mrs. Inez Nelson, Orlando	Mrs. Phyllis Leonard, St. Augustine	Sarasota, 1938
Pediatric Society	Douglas D. Martin, Tampa	Warren Quillian, Coral Gables	Miami, May 9, 1938
Pharmaceutical Association	Mr. R. Q. Richards, Ft. Myers	Mr. A. W. Morrison, Miami	
Radiological Society	Gerard Raap, Miami	H. B. McEuen, Jacksonville	Miami, May 9, 1938
Railway Surgeons' Association	J. R. Wells, Daytona Beach	H. D. Clark, Ft. Pierce	Miami, May 9, 1938
Chattahoochee Valley Med. Assn.	J. J. Clark, Atlanta	Frank K. Boland, Atlanta	Albany, Ga., July 12, 13, 193
Gulf Coast Clinical Society	H. L. Bryans, Pensacola	J. H. Baumhauer, Mobile, Ala.	Pensacola, 1938
Seaboard Railway Surgeons' Assn.	Joseph D. Collins, Norfolk	J. W. Palmer, Ailey, Ga.	December, 1938
Southeastern Derm. Assn.	J. L. Kirby-Smith, Jacksonville	Joe Elliott, Charlotte, N. C.	Charlotte, Sept., 1938
Southeastern Surgical Congress	Fred W. Rankin, Lexington, Ky.	B. T. Beasley, Atlanta	Louisville, March 7-9, 1938
Southern Medical Assn.	Frank K. Boland, Atlanta	Mr. C. P. Loranz, Birmingham	Oklahoma City, 1938
Suwannee River Medical Society	W. M. Ives, Lake City	H. S. Howell, Lake City	



COMPONENT SOCIETIES BY DISTRICTS—FLORIDA MEDICAL ASSOCIATION

Districts	COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR *and Counties Not Included in First Column*	Members Total	Members Paid
Northwest District (A) Panama City July 14, 1938	Bay	W. J. Blackshear, M.D., Panama City	William C. Roberts, M. D., Panama City		A-1-'38 John S. Turberville, M. D., Century	12	8
	Escambia	J. M. Hoffman, M. D., 1221 E. DeSoto St., Pensacola	J. N. McLane, M. D., 204 W. Brainard St., Pensacola	2nd Tuesday 8:00 P. M.		41	12
	Walton-Okaloosa	A. G. Williams, M. D., Lakewood	R. B. Spires, M. D., DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	B. W. Dalton, M. D., Vernon	R. H. Segrest, M. D., Bonifay		*Santa Rosa*	8	0
	Jackson	D. A. McKinnon, M. D., Marianna	R. N. Joyner, M. D., Marianna	2nd Tuesday 7:30 P. M.	A-2-'39 N. A. Baltzell, M. D., Marianna	15	11
	Leon-Gadsden-Liberty-Wakulla-Jefferson	W. D. Rogers, M. D., Chattahoochee	B. A. Wilkinson,, M. D., Telephone Bldg., Tallahassee	Quarterly 3:00 P. M.	*Calhoun-Franklin-Gulf*	38	16
North Central District (B) Gainesville, October 27, 1938	Columbia	William S. Nichols, M. D., Lake City	Harry S. Howell, M. D., Blanch Hotel Annex, Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M. D., Lake City	16	13
	Madison	E. Long, M. D., Madison	Geo. O. Davis, M. D., Madison			4	
	Taylor	G. H. Warren, M. D., Perry	J. C. Ellis, M. D., Perry	Last Friday 8:00 P. M.	*Baker-Dixie-Hamilton-Lafayette-Suwannee*	8	6
	Alachua	T. A. Snow, M. D., 105 E. University Ave., Gainesville	H. M. Merchant, M. D., 124 E. University Ave., Gainesville	2nd Friday 7:30 P. M.	B-4-'38 A. B. Albritton, M. D., Wildwood	26	7
	Marion	Carney W. Mimms, M. D., Commercial Bank Bldg. Ocala	R. C. Cumming, M. D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P. M.		22	18
	Pasco-Hernando-Citrus	W. Wardlaw Jones, M. D., Dade City	G. R. Creekmore, M. D., Brooksville	2nd Thursday 7:00 P. M.		14	11
	Sumter	Clyde L. Carter, M.D., Wildwood	W. E. Mitchell, M. D., Bushnell	2nd Tuesday	*Bradford-Gilchrist-Levy-Union*	5	4
N. E. District (C) Ponte Vedra Sept. 15, 1938	Duval	J. Lunsford Boone, M. D., 500 Professional Bldg., Jacksonville	George W. Croft, M. D., 713 Greenleaf Bldg., Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M. D., Jacksonville	161	98
	St. Johns	John J. Spencer, M.D., 32 Saragossa St., St. Augustine	Vernon A. Lockwood East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	*Clay-Nassau*	11	
	Putnam	Z. Brantley, M.D., Grandin	Allen P. Gurganious, M.D., Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'38 Hugh West, M. D., DeLand	10	6
	Volusia	Hugh West, M. D., DeLand	R. L. Miller, M. D., 258½ S. Beach St., Daytona Beach	2nd Tuesday 7:30 P. M.	*Flagler*	39	19
Southwest District (D) Bradenton, September 29, 1938	Hillsborough	Joseph W. Taylor, M. D., 706 Franklin St., Tampa	James S. Grable, M. D., 811 Citizens Bank Bldg., Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M. D., Plant City	100	1
	Manatee	John F. Mason, M. D., Bradenton	M. M. Harrison, M. D., Bradenton	3rd Tuesday 7:00 P. M.		13	12
	Pinellas	J. A. Strickland, M. D., 712 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D., 1005 Equitable Bldg., St. Petersburg	1st and 3rd Fridays 6:30 P. M.		91	70
	Sarasota	O. H. Cribbins, M. D., 224 Commercial Court, Sarasota	J. E. Harris, M. D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P. M.		16	12
	DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring	Howard V. Weems, M.D., Sebring	2nd Tuesday 8:00 P. M.	D-8-'38 J. A. Simmons, M. D., Arcadia	19	
	Lee	H. Quillian Jones, M. D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M. D., 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P. M.		13	11
	Polk	W. W. Shafer, M. D., Haines City	J. R. Boulware, Jr., M. D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	*Charlotte-Collier-Glades-Hendry*	61	39
South Central District (E) Leesburg, Nov. 10, 1938	Brevard	G. E. Christie, M.D., Titusville	I. K. Hicks, M.D., Melbourne	3rd Tuesday	E-9-'38 W. C. Page, M D., Cocoa	11	7
	Lake	Harry T. Fenn, M. D., Mount Dora	W. L. Ashton, M. D., Umatilla	1st Thursday 12:30 P. M.		17	15
	Orange	H. A. Day, M.D., 209 Exchange Bldg., Orlando	Hewitt Johnston, M. D., Box 2002 Orlando	3rd Wednesday 8:30 P. M.		69	54
	Seminole	J. N. Tolar, M. D., Sanford	Douglas G. Scott, M. D., Box 489 Sanford	2nd Monday 7:00 P. M.	*Osceola*	13	100%
	St. Lucie-Okeechobee-Indian River-Martin	R. C. Boothe, M.D., Ft. Pierce	Adrian M. Sample, M.D., Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M. D., Ft. Pierce	14	13
S. E. District (F) Ft. Lauderdale Oct. 17, 1938	Broward	A. B. Connor, M. D., Sweet Bldg., Ft. Lauderdale	Oliver C. Brown, M. D., 915 Sweet Bldg., Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'38 F. K. Herpel, M D., West Palm Beach	31	23
	Palm Beach	V. M. Johnson, M.D., Good Samaritan Hospital, W. Palm Beach	J. R. Sory, M.D., 616 Harvey Bldg., West Palm Beach	4th Monday 8:00 P. M.		56	28
	Dade	Arthur H. Weiland, M. D., 227 Aragon Ave., Coral Gables	Claude G. Mentzer, M. D., 808 Huntington Bldg., Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M. D., Miami Beach	277	114
	Monroe	Harry C. Galey, M. D., 532 Fleming St., Key West	W. R. Warren, M. D., 511 Eaton St., Key West	1st Sunday 9:00 P. M.		3	



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NEXT SESSIONS

Florida Medical Association, Miami, May 9-11, 1938.
American Medical Association, San Francisco, June 13-17, 1938.
Southern Medical Association, Oklahoma City, 1938.

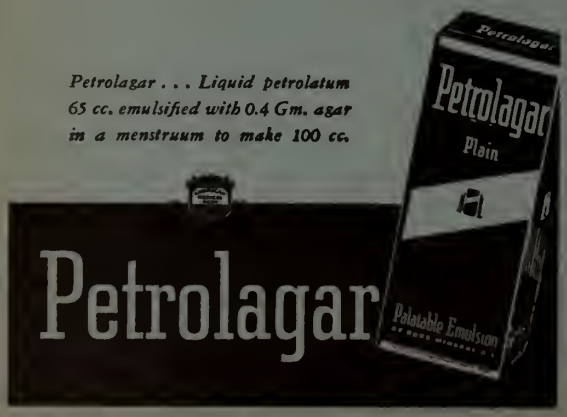
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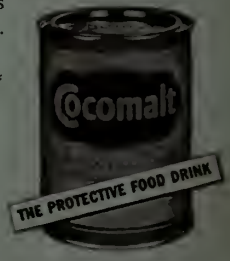
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Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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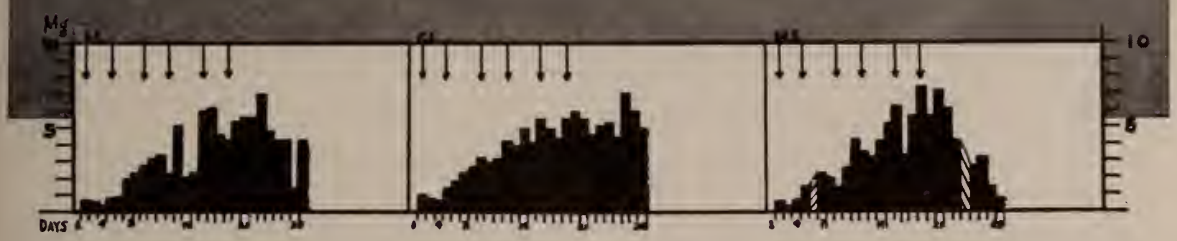


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[1] Sollmann, T., Cole, H. N., Henderson, K., *et al.: Amer. J. Syph. Gon. & Ven. Dis.* 21:480 (Sept.), 1937.

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THE USE OF X-RADIATION IN CONDITIONS OTHER THAN MALIGNANCY*

GERARD RAAP, M.D.,
Miami

When a therapeutic modality is claimed to be a panacea for all ills, we may look upon it with distrust. It is because of the critical attitude of the radiologists of this country that x-radiation and its beneficial effects in certain conditions have not been flaunted before the general medical profession. Although for years the literature contained an occasional reference or case report in which reliable results had been obtained, it is only recently that pioneers in this field have had the temerity to list certain classifications in which radiation may be considered the best method of therapy. Dr. W. F. Manges, whom we all respected greatly, published an article in the Southern Medical Journal of March, 1937, covering this subject very clearly and included an extensive bibliography of the literature for the past ten years. Dr. Fred Hodges made this the subject of his Presidential talk for the Southern Medical Association about one year ago. In a recent Journal of the American Medical Association, dated March 13, 1937, there appeared an article by Dr. S. Ayres, and several others interested in dermatology, on the value of radiation in infections.

Obviously, there must be a logical rationale to its use. It has been observed that in conditions in which leukocytic and lymphocytic infiltration is marked, there the results from radiation are best; also, that there is a definite tendency for these cells to break down under radiation. The clinical experiment is simple. Given two furuncles arising at the same time in the same individual, the radiated lesion will progress through its course in less than half the time of the untreated, with amelioration of symptoms and a demonstrated tendency toward walling off within a short period after radiation.

In this group we may include furunculosis and carbuncles, also paronychia, felon, pelvic infection, periproctitis, infection from human bites. The course of the average abscess is decreased as to time by about fifty per cent and it is quite customary to have the patient describe a period of about four to six hours after radiation during which pain may be slightly increased and after which it subsides quite rapidly. In some instances it is necessary to open these abscesses surgically but in most cases this is hardly necessary. The very early radiation of an abscess frequently aborts the process. In carbuncles after two or three treatments on successive or alternate days drainage and localization are enhanced, and as a result crucial incisions may be entirely avoided and scarring is not nearly so marked. The mortality among the conservatively treated cases is 50 per cent as high as that among cases treated by surgical methods.

I wish particularly to emphasize infections about the face. To the seasoned physician one need not stress the frequency of spread from these minute lesions about the nose, neck and upper lip to the vessels of the brain, or of general septicemia. During the year 1926, in one hospital, I saw three of these patients with fatal results in a period of a few months. Since that time I have seen one fatality in spite of radiation, and have treated some cases in which the evidence of septicemia was already apparent. In one family I treated a mother who died two hours after radiation, the condition having been present for five days previously with surgical procedure forty-eight hours previously. In that same family, on two separate occasions, the daughter has been treated by radiation alone, with satisfactory results. By radiation alone is meant total abstinence from any added procedure, even the use of compresses, since I have sufficient confidence now in the ability of radiation to wall off infections.

When mention is made of infected rhinophyma, infected angioma, blastomycosis,

*Read before the Sixty-fourth Annual Meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, 1937.

parotitis, Mikulicz's disease, you will note that all of these can be classified in the same group. Acute otitis media has been especially separated to call your attention to the splendid exposition of this subject by Dr. Joseph Lucinian in the Holmes memorial number of the Journal of Roentgenology and Radium Therapy. We felt it our duty to comment on this in our local Bulletin and have also called it to the attention of the State Journal. Others have described its value in chronic catarrhal otitis and deafness.

In erysipelas, it has been my experience that x-radiation is specific while the lesion is localized but when widespread I rather favor ultraviolet radiation and the use of erysipelas serum. Although not proved, I am of the impression that in these cases the use of x-radiation over too large an area of the body may be somewhat disadvantageous.

In thrombophlebitis and in lymphangitis, particularly where superficial induration and low grade cellulitis are marked, radiation has a distinct place. I recall one case of a young man with a well-marked cardiac impairment whose work required long hours on his feet, and who periodically developed a lymphangitis of one leg in which the use of radiation has been most effective. Five years ago this patient lay in the hospital for five weeks, dressings of every variety being applied. In desperation, the clinician asked that radiation be given a trial. Within forty-eight hours he was on his feet, and the swelling and redness had entirely disappeared. Since then, at the slightest suggestion of further trouble, this patient requests therapy.

Doctor Payton and I recall listening to a modest radiologist from Decatur, Ill., who at one of the national radiologic conventions narrated his experience with a case of gas gangrene which came to his attention. He stated that with a mobile x-ray unit he treated this patient and in doing so burned out two radiographic tubes. Strange to say, his patient recovered. Kelly, of Omaha, then stated that he had used radiation in a few of these cases but due to the fact that these patients had also had surgical procedure and perfringens antitoxin his experiment had not been under control. Since that time radiologists have shown that cases in which the extremity has already become apparently gangrenous and surgically hopeless, radiation has produced completely satisfactory results. In this field I have had similar results and in one instance even the patient is willing to describe the subjective change which occurred after radiation when he was already moribund and we did not know there were any consciously registered subjective phenomena.

A recent issue of the A. M. A. Journal describes favorable results in bronchiectasis. The results of this procedure remain to be proved. However, the modus operandi appears rational and I plan to try it.

A group of conditions has been listed for you in which infection plays an important role, and in which generally favorable results have been produced by all who have used radiation. There is another group which includes the meningitides and encepholitides. An increasingly larger number of reports calls attention to the results obtained by judicious radiation of the spine and skull. On acute epidemic spinal meningitis alone there appeared last year three distinct reports, all showing a promising percentage of favorable results.

Radiation as related to control of glandular activity is a complicated, but at the same time a most interesting and fertile field for study. It may be a two-edged sword and experience must give us acuity of judgment and the natural result will necessarily be an extreme cautiousness. This cannot develop if the radiologist imitates the pharmacist, who fills a prescribed dosage using the method dictated by the internist or endocrinologist who knows nothing of the sequelae of haphazard radiation. Usually he does not know that there is a cumulative effect in radiation but wishes to use it like a drug—if one dose does not produce the desired result, keep giving the patient some more. We shall revert to this thought by illustration after mentioning some of the phenomena of radiation of glands.

Many of you have heard of the use of radiation in hypertension. Hutton of Chicago described it some four years ago. It is effective in certain types of cases, but it is difficult to classify these. He advises radiation over the adrenals and pituitary, but we have also seen favorable results from radiation of the

carotid body, and from radiation of ovaries and prostates. You ask, why this apparent vagary? We shall probably know the answer when you tell us what constitutes the mechanism of essential hypertension. It has also been stated that in the phenomena of menopause, radiation will produce startling changes when applied to the pituitary gland. A group in New Orleans seems to feel that this is an innocuous procedure. Possibly so, but I once saw a case of Simmons' disease, also known as pituitary cachexia, autopsied, and later heard of three cases in which this cachexia developed after radiation of the pituitary. The pituitary may be considered the baton of the glandular orchestration, and we may be safer in correcting the drummer or the piccolo-player, until we know definitely that the fault lies in the leader of this temperamental group.

It has been observed that in young women with breast malignancy, the frequency of metastasis is apparently decreased by castration. In view of the recent biochemical research work showing the close similarity between well-known carcinogenic agents and oestrin substances, this may be considered rational.

Certain cases of myasthenia gravis which are accompanied by thymoma and thymic hyperplasia, are amenable to radiation. The group of glands in the neck are readily accessible to radiation and as such permit rather accurate study of the value of radiation in glandular aberrations. Previous to qualified surgery of the thyroid, many cases were treated by radiation. There followed a period in which surgery became the vogue. Now we again find the results from radiation equally satisfactory, especially since the mortality rate from surgery has increased in the last few years by virtue of the fact that not as many thyroidectomies are being done and fewer men are able to qualify as goitre specialists. This does not necessarily reflect on the surgical attitude toward the thyroid.

Rarely does one find a surgeon trained in thyroid surgery who chooses to operate for the removal of the parathyroid glands. The results from surgery and radiation in these cases of hyperparathyroidism and osteitis fibrosa cystica have been about the same. We have some cases in which radiation of these glands produces the most dramatic changes. Others do not do so well.

We revert to the thought previously expressed, that results in these conditions depend on the clinical study which the radiologist can give these cases, or stating it more specifically, but not facetiously: What can you expect if a glandular dystrophe patient is being given theelin several times a week, parathormone injections, pancreatin with every meal, adrenal cortex every once in a while and at the same time is told to go to the x-ray man who will give a few x-ray treatments. Yet this actually happened in my own experience, and in that instance under occasional radiation of the parathyroid, the patient has discarded an orthopedic brace for her spine, is now working and one month ago had her first menstrual bleeding in thirty-two years.

Radiation has been used in syringomyelia for a number of years, radiation of the spinal cord being about the only effective agent. Reiva Rosh has reported good results in psoriasis of long standing. In gastric ulcer, radiation of nerve roots has been advised. Tic douloureux and other neuritides seem to be amenable in certain instances.

Kindly bear in mind that although a number of conditions have been listed, they all fall into certain classifications and that the only ones suggested are those in which such classification is clearly defined.

As to dosage, the answer is "the Latins had a term for it" the word is "Modicum." I do not wish to utilize the time to discuss this in a meeting of this type. It varies with the radiologist, the patient, and the disease, just as any other therapeutic agent. I only state that in the aforementioned, the radiologist has the best method of treatment, in others he has as good a method as previous methods, and in a few instances his efforts may be a helpful adjunct.

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908 Huntington Bldg.

DISCUSSION

J. W. Snyder, M. D., Miami:

I am sure after hearing Doctor Raap's excellent presentation in the therapeutic field, we shall all be tempted to install x-ray equipment

or feel quite behind the times in our therapeutic endeavors.

It is indeed a pleasure to find enthusiasm and pioneering in any field of medicine. More power to our roentgenologic conferees. However, we should at all times keep both feet on the ground and not be carried away by each new procedure until its real merit and potential dangers are definitely proved. I, personally, feel that the novice has no place in x-ray therapy, since so much harm can follow misguided radiation that only the well qualified radiologist should attempt such measures.

We are all pleased to admit the real value of radiation in superficial inflammation but of its value in infections of the internal organs we are not so sure. If good results are to be expected, as indicated by Doctor Raap's presentation today, we shall feel greatly indebted to radiology for such an advance.

Radiation of the glands of internal secretion may be a two-edged sword to be handled with extreme care as the essayist has intimated. This is a very promising field of which, at present, we know so little that all therapy is beset with doubt and uncertainty. We should therefore caution our radiological friends to proceed with care until their foundation has been well laid. I certainly wish to disagree in the thought that x-ray can in any way approach surgery in the treatment of hyperthyroidism. I have yet to see a single clear-cut case in which a cure has resulted.

Doctor Raap is to be commended for his excellent survey of the subject and radiologists in general for their courage and enthusiasm in attempting new conquests.

Dr. Gerard Raap, Miami (Concluding):

I certainly wish to thank Doctor Snyder for his fine comments about this paper. Naturally, we have our differences of opinion in the treatment of hyperthyroidism and each of us feels that we have a good reason for taking the stand we do.

ACUTE HEMATOGENOUS OSTEOMYELITIS*

Ferdinand A. Vogt, M. D.
Miami

Acute hematogenous osteomyelitis is an acute bacterial inflammatory lesion of bone occurring as an incident or secondary to a general bacterial infection.

Etiology—The common causative agents are usually the staphylococcus aureus, streptococcus and, less frequently, the pneumococcus, colon and typhoid bacilli. These organisms enter the blood stream from infections of the skin such as boils, carbuncles, wounds and abrasions. This is particularly true of the staphylococcus, while the streptococcus enters from infections of the mouth cavity and throat. The predisposing causes are: age, (statistics show that most cases occur between the ages of two and ten years); general debility from whatever cause; localized trauma which probably lowers the resistance of the tissues near the epiphysis.

Pathology—The bacteria localize in the bone on the diaphyseal or shaft side of the epiphysis and there produce an infective process which results in an inflammation of the cancellous bone. On account of the inelasticity or resistance of the bone to expansion, necrosis with destruction of the trabeculae results within twenty-four to forty-eight hours. Pus then forms and begins to spread in the line of least resistance—usually toward the periosteum. This latter is raised from the bone and the process may extend the entire length of the shaft and around it. The space thus formed is filled with pus. Extensive bone destruction may follow. The tension of the exudates is sooner or later relieved by rupture of the periosteum or operative incision. Involucrum or new bone is then laid down by the periosteum and an attempt at regeneration made. The sequestrated bone is soon separated and may be absorbed entirely, may be cast out of the body by spontaneous rupture of an abscess, or removed by surgical attack. Then the process passes into the subacute or chronic stage.

Symptoms—The onset is usually sudden, with pain of a throbbing, severe, and continu-

*Read before the Dade County Medical Society, May 7, 1937.

ous character, appearing in the neighborhood of a joint and near the end of a growing bone. This is accompanied by a moderately high fever and a leukocytosis of from 20,000 to 30,000. These patients are frequently extremely toxic and have all the signs of an acute blood stream infection. Tenderness may be elicited over the epiphyseal line, but in the early stages there is no swelling or redness in this location because the infection is still in the bone and has not reached the periosteum. Later, when the periosteum is involved and finally ruptures, one can palpate a mass which is usually fluctuant. When this occurs, there is some relief of pain and the toxic symptoms begin to abate.

The blood culture is frequently positive for staphylococcus or streptococcus. The x-ray signs are usually not present in the early stages. It is only in the second week of the disease and later that the x-ray can detect any significant changes.

Treatment—Until a few years ago most medical men and surgeons alike agreed that acute osteomyelitis should be treated as an emergency and operated on as soon as the diagnosis was reasonably certain and most of us have had the same opinion. Starr, in his classical monograph on the disease, states: "Immediate treatment should be instituted as soon as a diagnosis is made and the first principle is to relieve the tension beneath the periosteum and in the cancellous area of infected bone. The periosteum is incised and then a trap door is made through the cortex and drill holes completed into the cancellous bone. Such treatment relieves symptoms of pain and toxemia and in most cases prevents necrosis and subsequent sequestra." Dr. John B. Murphy used to impress upon his class of medical students the urgency of operation in these cases. There were very few surgeons in those days who would dare treat one of these cases conservatively.

Since the mortality rates have continued to remain high under this plan of treatment and since many patients not operated upon have been observed to recover without abscess formation and the sequestra have been absorbed, there has recently been noticed in the literature a more conservative trend toward the treatment of this disease. Wilensky of New York, in the *Archives of Surgery*, January, 1937, reports several cases showing that radical operations have no effect on the course of the disease and may do great damage. Frequently foci of acute hematogenous osteomyelitis subside completely and spontaneously without going on to the stage of necrosis and sequestration. He finally says that when operation is necessary it had best be confined to the simplest of procedures, incision and drainage of abscesses.

Crossan, after a study of some 120 cases stated: "Decompression in the early stages of the disease is a decimating procedure and incision is a safe measure at any time, preferably not immediate." He feels sure the conservative treatment will permit the patient to wage his own fight in a more efficient manner. Humphries reports 20 cases, all treated conservatively with no deaths. In 7 cases there was healing without abscess formation and in the other 13 cases the abscess opened spontaneously. He concludes: "Operation is not only useless, but is positively harmful. The sequestra will be carried off by the blood stream if left alone." There were four infants in this series.

Robertson, in studying 75 cases found a mortality rate of 28.6% in those cases with a positive blood culture. He concludes: "The best results were obtained by drainage of the bone within one week following the onset. The mortality was also highest in cases in which drainage was instituted within this period."

Wilson & McIver (*J. of Bone and Joint Surgery*) analyzed 98 patients admitted to Children's Hospital, Los Angeles, from 1928 to 1934. The mortality rate was 12.2 per cent. An effort was made to determine the effect of early and late operations as to mortality and development of secondary foci. Six patients died within the first week and five of these within the first twenty-four hours after operation. Two patients died during the second week, three within the next eight days and one survived for 220 days. In a group of 24 patients treated by early surgical medullary drainage, six or 25 per cent, died; three within 24 hours after operation. In another group of 31 patients in whom drainage was done from the seventh to the twenty-eighth day of illness, 3 or 9.7 per cent died. The mortality rate dropped 15 per cent when drain-

age was done after the first week of illness. In 23 patients whose abscesses drained spontaneously, only one died and his death resulted from a complication. The highest percentage of metastatic lesions was in the early drainage cases and the lowest in the groups where drainage was done after the seventh day.

Green (*J.A.M.A.*, Dec. 7, 1935), in discussing osteomyelitis in infancy, says that it is a disease of relatively brief duration with sequestra and recurrences rare and residual lesions in the bone unusual, if the child survives the acute illness. The mortality rate may be reduced by allowing localization and by carrying out the simplest surgical procedures.

Leveuf, in concluding a study of 16 personal cases, states that the advantage of conservative treatment cannot be overemphasized. As the disease develops the forces of the organism should be well supported. The involved part should be placed in a plaster jacket for rest and early trephination should be avoided.

Reviewing 50 cases of acute osteomyelitis that were admitted to Jackson Memorial Hospital in the last 10 years, we found that only about 30 records could be used for any kind of statistical analysis. The charts were very incomplete, particularly as to the history of the disease and, consequently, we could learn in but a few cases what day after the onset operation was done. However, we found that of these 30 patients, 4 died; a mortality rate of 13 per cent. This compares favorably with results elsewhere. The average age was 9; the youngest was 16 months. In three cases no operation was performed and none of these patients died—ages 2½, 4, and 9 years. Of the remaining 27 cases, 6 patients were operated upon early, within 7 days after onset of illness, and 3 died. One died the day of operation, another 4 days afterwards, and the third died 4 months afterwards. The other 21 patients were operated upon late—the majority over 2 weeks after onset. A great many of these might be considered as subacute or chronic cases but they show us what happens when operation is not done early. In all, abscesses or sequestra were demonstrated at operation. Many, on admission to the hospital, had draining sinuses, due to the spontaneous rupture of abscesses. Others had multiple lesions and evidence that joints were involved, resulting in some degree of ankylosis.

Statistics are sometimes very confusing and misleading. For instance, the 3 patients who were not operated upon and lived would probably have lived with operation and the converse applies to the 3 who died following operation. These patients do not die from the lesion in the bone, but from the toxemia of the general bacterial invasion. Neither did incision and drainage of the bone cause the multiple lesions. They are produced by the same original infection. Osteomyelitis from the operative trauma did not develop in two cases of bacteremia in which operation for osteomyelitis was done by mistake.

After this study and review, we wonder if this trend toward conservative treatment may not be carried too far. What really is the objection to operation even if done early? Is the procedure of making an incision through the skin and muscles to the bone and then boring a few holes through the cortex into the cancellous part so formidable and shocking that it will cause death or lower the resistance of the bone operated on so that more infection takes place? We believe not. On the other hand, we believe opening the bone early releases the pressure in the cancellous tissue and prevents spread of the infection to the epiphysis and shaft, although it may have nothing to do with shortening the course of the general infection.

Each case of acute osteomyelitis should be individualized. After admission to the hospital the bacteremia and toxemia should be combatted and an attempt made to determine the patient's general condition. Blood is withdrawn for culture and counts, and repeated small blood transfusions given. Fluids are administered in the proper quantities. If the streptococcus is demonstrated sulfanilamide may be tried. The extremity that is affected is adequately immobilized by traction or splints and the exact location of the lesion in the bone determined. These patients should be prepared as carefully for surgery as in any other type of case. The operation should be thoroughly planned and done with the minimum of shock. After operation the same treatment as before should be continued and the limb thoroughly immobilized. The operative wound should not be disturbed until the dressings are thoroughly saturated with pus. If this plan is adopted, I believe there will be a decided lowering of the mortality and morbidity rates in this disease.

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Huntington Bldg.

THE DIAGNOSTIC VALUE OF THE NEUTRALIZING FUNCTION OF THE STOMACH*

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The question, "Why does not the stomach digest itself," has supplied a basic groundwork for experimental physiologists over a period of many years. Since 1856, when Claude Bernard revealed that foreign tissues such as live frog's legs anchored into dog's gastric juice would be digested away, the physiologist has ever been searching for the phenomena of immunity or protection which is enjoyed by each individual species between the gastric juice and its own tissues. All have well recognized that should this mechanism be discovered it would undoubtedly throw immense light upon the etiology of peptic ulcer.

In 1929 there was reported before this Society the experimental result dealing with the power of the gastric juice of the living dog to digest the tissues of another living species of animal, as well as that of his own tissues.[1] It was found that the back legs of a living frog when anchored through a window into the anterior wall of the stomach of a living dog would be completely digested away within six to twelve hours. On the other hand when the dog's own tissues such as the spleen or kidney were anchored into the window, even when the fibrous capsule had been previously stripped, there was no digestion even after several months of observation. This result held true for all of the many tissues exposed with the exception of one. When the external wall of a portion of the terminal duodenum or proximal ileum was anchored into the anterior window of the stomach, just as would be done in an anterior gastro-enterostomy, except that no stoma was cut into the intestine, an interesting finding at the second operation or at autopsy ensued. The gastric juice digested through the bowel wall and produced itself a stoma forming a perfect gastro-enterostomy opening. The only difference between this particular hook-up and that of the other tissues under which no tissue digestion took place, was that in anchoring the loop of intestine into the anterior window, the new position interfered by anatomical twisting with the normal blood supply to that portion of the gut and under these conditions the gastric juice uninhibited in some way could exert its digestive action. In other words the experiment indicated some antipeptic protective substance normally in the blood stream which protected the tissues of the animal against the action of its own gastric juice. This indication was partly confirmed by returning to the original experiments with the spleen and kidney but this time ligating their blood supply at the experiment in which case they were then digested. This, of course, is not definitely conclusive since the organs might undergo at least partial autolysis from lack of circulation by the ligation even in the absence of the gastric juice.

During the various investigations in search of an answer to our original question the physiologist has established for us that the normal concentration of hydrochloric acid in the human stomach is near 0.5 of one per cent. When this concentration of hydrochloric acid is titrated with tenth normal sodium hydroxide, (standard technique for titration of gastric juice) it is interesting to note that it titrates between 135 and 140 degrees or clinical units. Despite this fact we all agree that in clinical practice when we find a gastric juice which titrates a total acidity of 70 to 90 degrees, we term it a distinct hyperchlorhydria. A moment of reflection and thought convinces us that there exists some discrepancy.

The experimental work of Boldyreff,[2] Mac-

*Read before Florida East Coast Medical Association, Hollywood, November 12, 1937.

Lean and Griffiths,[3] and Matthews and Dragstedt[4] have shown that the contents of the normal stomach possesses a definite ability to neutralize hydrochloric acid when introduced in physiological concentration (0.5 per cent). This once established, various other investigators finally visualized the possibility of its clinical application, both in diagnostic routine and as a possible etiological factor in peptic ulcer. Elman and McLeod[5] applied the principle clinically to peptic ulcer and found that there was a decrease in the power of the stomach to neutralize 0.5 per cent hydrochloric acid as compared to the normal curve which they established. (See various graphs). Levy[6] confirmed their observations and in addition established its application to pylorospasm and chronic appendicitis. Phillips[7] in a preliminary study then subjected the test to various diseases connected to or associated with the digestive tract and found that in addition to ulcer and pylorospasm there was indication of possible value in liver and gall bladder disease.

This report is intended to convey the results of further experience with the test as to its clinical value in diagnostic routine. The study has extended over a period of four years and has been applied to one hundred and sixty-eight different patients. The total group subdivided itself into the following sub-classifications: normals, peptic ulcer, pylorospasm, liver and gall bladder, gastroclonic syndromes, allergic disease and miscellaneous. Detailed discussion regarding these sub-groups is presented in the preliminary report[7] and is therefore omitted here for the sake of brevity. Additional study and experience have revealed little change except in liver and gall bladder disease which will be further discussed.

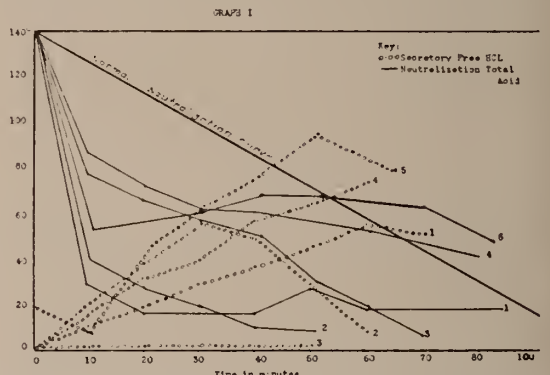
TECHNIQUE

Either the single or combined technique may be used with sufficient clinical accuracy to be practicable. The single technique consists of passing a small duodenal tube, the same as for fractional gastric analysis, emptying the stomach of its fasting contents, and then instilling 150 cc. of 0.5 per cent hydrochloric acid into the stomach. Small specimens (5 to 10 cc.) are aspirated at ten-minute intervals for 70 to 120 minutes. Specimens are titrated with tenth normal sodium hydrate using phenolphthalein as an indicator and plotting a fractional curve. Saliva containing mucus should be expectorated during the test.

The combined technique gives the secretory curve for comparison. It consists of passing the tube, aspirating the fasting stomach, instilling 150 cc. of 7½ per cent alcohol and then aspirating 10 cc. specimens every ten to fifteen minutes for one or two hours. The fractional secretory curve is thus obtained. The stomach is then emptied and 150 cc. of 0.5 per cent hydrochloric acid instilled and the neutralizing curve obtained as above described.

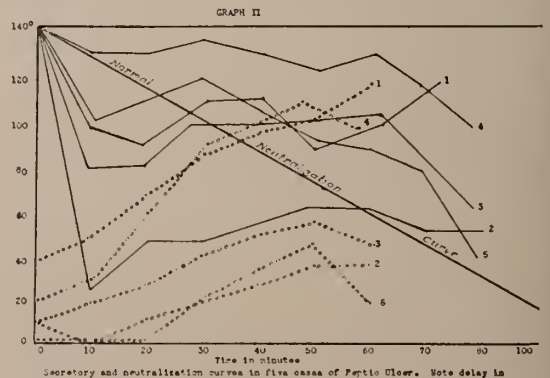
RESULTS

Reference to Figure 1, Graph I reveals the variation in neutralizing power in normal in-



Secretory and neutralization curves in five normal cases. Note normal variation in neutralizing power, independent of secretory curves.

dividuals. Their secretory curves are also shown in the graph. While they do not follow with precision the normal neutralization curve as established by Elman and McLeod, it will be observed that they tend to conform to its general direction. When these curves are compared to Graph II representing those of

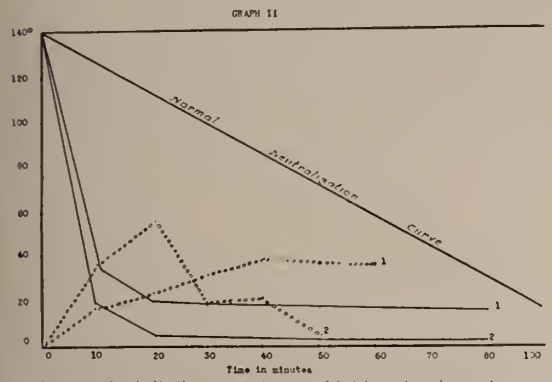


Secretory and neutralization curves in five cases of Peptic Ulcer. Note delay in curves as compared to normal neutralizing curves in Graph I.

FIGURE I

peptic ulcer; it will be seen at once that in the latter there is a distinct delay or decreased

neutralizing ability shown on the part of the stomach in the ulcer cases. Contrast these now with figure 2, Graph II constructed from

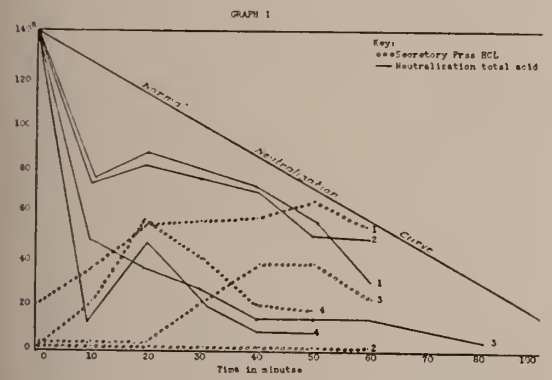


Secretory and neutrellization curves in two cases of Gastric carcinoma (proven at autopsy). Note increased neutralizing power in presence of normal free HCL.

FIGURE 2

two cases of proven gastric carcinoma and note that even though the secretory curves are within normal there is a distinct increase in neutralizing power.

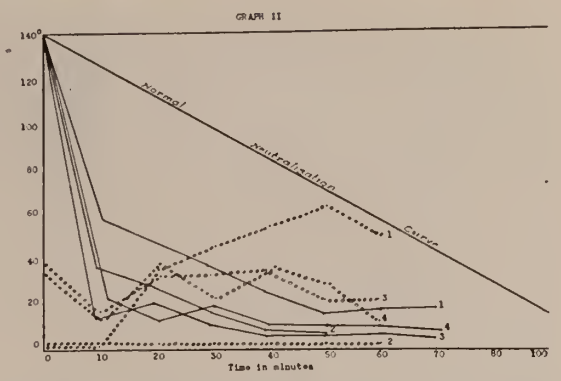
In the group presenting vague gastro-intestinal symptoms the secretory and neutralizing curves vary and present no diagnostic criterion, Figure 3, Graph I. On the other hand,



Secretory and neutralization curves in four cases of vague gastro-intestinal symptoms. No organic findings except spastic colon.

Figure 3, Graph II, the liver and gall bladder disease group (all proven at operation or autopsy) present a definite, increased neutralizing power. Over fifty cases of proven liver and gall bladder disease have been studied and in over ninety per cent the neutralization curves show a drop and this regardless of the secretory curve. It would appear that our suggestion in the preliminary report that the test is of value in differentiating between ulcer and gall bladder disease is being borne out.

In the ulcer or pylorospasm group there is

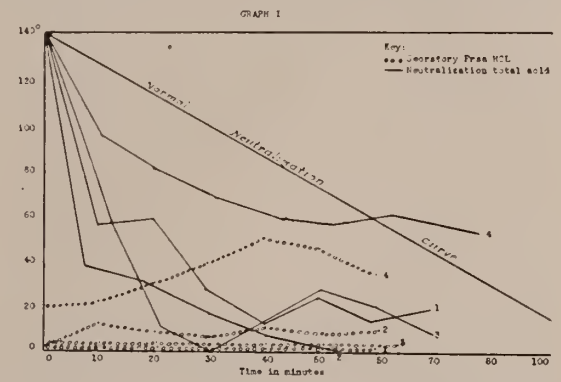


Secretory and neutralization curves in four cases of liver and gall bladder disease. Note increased neutralizing power independent of secretory curves.

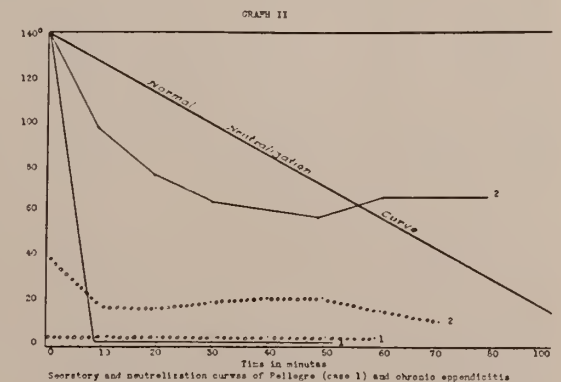
FIGURE 3

a delay in the fractional neutralizing curve while in liver and gall bladder disease the curve tends to drop far below the approximate normal curve. These two characteristics apparently hold true regardless of the secretory curve which in many cases will not aid in differentiating between these conditions.

We have found the test curves so variable in the so-called gastro-intestinal allergies, as well as the various diseases in the miscellaneous group, that it is of no diagnostic value.



Secretory and neutralization curves in four cases of allergic disease. All within normal with the exception of Case 4.



Secretory and neutrellization curves of Pellegra (case 1) and chronic appendicitis with ovarian cyst (case 2). Note marked increase in neutralizing power in case 1; delayed in case 2.

FIGURE 4

MECHANISM OF NEUTRALIZATION

Modern views of how this neutralization is brought about include: duodenal regurgitation, mucus and acid binding substances, cessation or inhibition of hydrochloric acid secretion, alkaline secreted gastric juice, acceleration of the emptying time of the stomach with associated secretion of a less concentrated juice, resorption of the secreted or introduced hydrochloric acid by certain portions of the stomach.

The most widely supported of these, first sponsored by Boldyreff, is that of regurgitation of duodenal contents. While undoubtedly this plays an important role in the neutralizing mechanism it is not the entire answer to the problem. Shay, Katz and Schloss[8] have shown that regurgitation from the duodenum is even greater when alkalis (1-1½% $NaHCO_3$) are introduced into the stomach than when weak or strong acids are used. This speaks against Boldyreff's basic theory that the regurgitation is due to the intestines refusing to accept an acid stronger than 0.1 to 0.15% HCL. We have frequently observed that the greatest amount of regurgitation occurs in patients with achylia gastrica during a plain water meal. Furthermore although the dye bromsulphthalein changes color at a pH of 7.2 we have been unable to obtain color changes from regurgitated duodenal contents even in the presence of achylia gastrica. In two of the cases of carcinoma, Figure 2, Graph II, even in the presence of extreme pyloric obstruction and relatively high secretory curves, the neutralizing power was much increased producing a sharp drop. It is, therefore, doubtful as to the extent of the part played by regurgitation in the neutralizing function.

McCann, utilizing the Mann-Williamson operation which shunts all duodenal contents into the terminal ileum, found that the neutralizing power of the stomach remained the same before and afterward.

Isolated pyloric pouches have shown that the secreted mucus is neither sufficient in amount of alkalinity to account for the acid reduction. We must, therefore, give considerable attention to the possibility of resorption or diffusion of hydrogen ions through portions of the stomach wall or that the stomach itself is actually capable of secreting an alkaline juice as advocated by Author.

Dilution plays some part in the mechanism as indicated by adding a coloring matter (sodium salt of phenolsulphonphthalein) to the acid test meal and determining its concentration in the fractional specimens by means of a colorimeter. If the strength of the acid in the meal and the fractional samples are determined by chemical analysis instead of by titration, it will be found that from 50 to 60 per cent of the reduction is due to dilution and 40 to 50 per cent to neutralization.

Both clinical and experimental recent reports tend to show that the emptying time of the stomach plays very little if any part.

CONCLUSIONS

(1) The neutralizing functional test of the stomach is of diagnostic value in ulcer, pylorospasm and liver and gall bladder disease.

(2) Its potential value in carcinoma is indicated.

(3) Various mechanisms for the neutralization are discussed.

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FRACTURES OF THE SPINE*

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In a topic of this broad nature it will be possible to dwell but casually on a few high lights that illustrate striking clinical facts. There is no pretense therefore at covering this topic fully nor even the subjects presented in any detail.

ETIOLOGY

The etiology of compression fractures of vertebral bodies may be a surprisingly minimal trauma, such as sitting down or jackknifing suddenly, or perhaps as in one case as little as an 18-inch fall. Attention is called to this as investigation is often neglected because the trauma is considered trivial. History and physical examination in these less spectacular types of injury are usually misleading for the reason that an ordinary strain or wrenched back will give far more signs and symptoms of injury than a slight compression fracture.

DIAGNOSIS

A chief method of differentiation clinically would be the persistance of local symptoms after a period of time during which we would expect soft tissue symptoms to have abated. The x-ray is our chief diagnostic agent, and also the measuring rod of therapeutic success both as to complete reduction and later union. Only the most modern equipment and exacting technique is capable of rendering visible evidences of many serious types of injury. As many as ten radiographs may be required including stereoscopic views in the anterior-posterior view; radiographs of one or more suspected vertebrae from superior and inferior angles; right and left oblique views and pictures with smaller cones for better detail. In the cervical spine the technique is even more exacting. Since dislocations of the atlas upon the axis is estimated by the relationship of the anterior and posterior tubercles of the former to the anterior surface and posterior spinous process of the latter, it can be readily understood how rotation of the head would render the radiograph valueless from a diagnostic standpoint. Fatalities have been recorded from such unrecognized details. It might be mentioned that one method for estimating a true lateral view of the cervical spine is to observe whether the rami of the mandible are superimposed and are not separated more than one centimeter in the lateral view.

The large majority of compression fractures occur about the twelfth dorsal and first lumbar vertebrae. The ribs and sternum hold the upper thoracic spine so rigidly that compression fractures are unusual. Fractures or dislocations in this area are caused by direct violent trauma, and are recognized by extensive displacement and comminution and often involve the laminae and pedicles. The compression fracture is diagnosed by a wedging of the vertebral body, the apex being anterior. The anterior border of the body affected is thus narrower than those above and below it. This wedging is often clearly visible only in the lateral view. There is also an increased density usually at the superior margin, anteriorly. After some time a certain amount of callus is deposited in the area of the compressed bone which is easily visible. A wedging of one or more vertebral bodies is also a common result of deformities of age and occupation. A wedge-shaped vertebra found in the upper half of the dorsal region with a history of a mild indirect trauma would not usually be considered the result of an injury, which might have accounted for the same deformity in the lowest dorsal segments. A true lateral view taken with an efficient machine will demonstrate the slightest degree of compression. It is quite possible that the much discussed but little seen Kümmell's disease, originally considered a rarefying osteitis caused by a circulatory disturbance at the time of the original trauma, was a slight compression fracture overlooked because of the poor apparatus and undeveloped state of technique then prevalent, until disintegration and collapse occurred at a later period.

Some of our conceptions regarding the treatment of fractured spines must be revised. Many cases recognized now, due to improved methods of diagnosis, were formerly overlooked entirely; these cases ended with chronic back pain, traumatic arthri-

*Read before the Tenth Annual Meeting of the Florida East Coast Medical Association, Hollywood, November 12, 1937.

tis, and perhaps a slight kyphos, but healed nevertheless by virtue of the immobilizing influence of the strong posterior spinal muscles. The well-developed musculature acted as an internal brace, however inefficient for prolonged duty. Recently upon discovering some of these lessor fractures formerly overlooked entirely, we are subjecting them to over-treatment; treating the diagnosis rather than the pathology. The diagnosis of fractured spines carries with it from other days fixed minimums of three months' bed rest and six months' immobilization and a prognosis filled with as much misgiving as those cases caused by direct force with considerable displacement and comminution.

TREATMENT OF FRACTURED SPINES WITHOUT PARALYSIS

It is remarkable to reflect that since 1920 we have advanced sufficiently to correct compression fractures at all. It is now generally recognized that a fractured vertebra can be reduced as readily and accurately as compression fractures elsewhere. It is even more important to achieve good reduction than in many other fractures, since a poor result means poor alignment, traumatic arthritis, a painful back, and the possibility of a spinal fusion to secure a painless immobility.

The treatment of the compression fracture without paralysis should be the same as fractures elsewhere. We would not hear of taking two weeks or two months to reduce other fractures. After a few weeks the wedged vertebra will not re-expand as it would on immediate reduction, and all chances for a well-aligned painless spine are lost.

It should be remembered in the diagnosis of compression fractures of the spine that in borderline cases the last word belongs to the clinician, not the radiologist. Compressed vertebrae of long duration disclose merely that on a radiograph, and it is up to the clinician to evaluate the facts as to whether the trauma was adequate to produce a deformity in a certain area of the spine or whether the changes could have been wrought by age, occupation, or diseases affecting the strength of bone.

Compression fractures of the spine are reduced by hyperextension, that is, a force opposite to the one causing the original injury. Hyperextension can be effected by means of a Roger's frame or one of its modifications in which the spine is hyperextended over a period of days until the check-up x-rays indicate the re-expansion of the anterior vertebral border of the affected vertebra; or hyperextension may be effected by Davis' method or one of its modifications in which either extremity of the prone body is raised until the same result is obtained. When shock or other modifying influences are eliminated in any particular case there is no reason why a patient should have to lie in bed any length of time before having his fracture reduced. Rather, as in any other part of the body, it can be promptly hyperextended as in the Davis method, a plaster jacket applied and the patient made ambulatory shortly thereafter. This early ambulatory treatment is not advocated for the 20% of spine fractures which are the result of direct force and in which laminae and pedicles may be broken and general fragmentation have taken place about the spinal canal. In these latter cases more conservative methods are correctly used. However, the simple compression fracture produced by indirect force can be made ambulatory within a week without danger. In these cases a well fitted unpadded plaster jacket must be used. The plaster jacket must extend up to the sternum and the first dorsal vertebra superiorly and down to the pubic bone and sacrum inferiorly. There may be an area removed immediately overlying the abdomen for comfort. If padding is used with a plaster jacket it makes for a laxity which will not hold a reduction properly. The spine does not collapse like an accordian but can only recompress itself by forward flexion, and this is impossible with a well fitting cast applied as described. The cast should remain on for approximately three months in a slight compression fracture, and approximately six months with a severe compression fracture showing some comminution. Braces are unnecessary since they do not give firm support if required and therefore tend to a false sense of security. Casts should be changed completely if required and not bivalved.

The treatment described is really a conservative one since by allowing the patient to be ambulatory, we prevent the disuse at-

rophy of the bones and musculature which occurs in the bedridden patient; by prompt and effective reduction we eliminate poor alignment and painful backs. As in well treated fractures in other parts of the body, good reduction and early mobilization dispense with the need for most of postoperative physiotherapy. When the casts are removed in a properly handled spine the patient is ready to resume his full occupation very shortly thereafter since his tissues have not been allowed to degenerate or malunite.

TREATMENT OF FRACTURED SPINES WITH PARALYSIS

Paralysis is caused by laceration of the cord, edema, hematomyelia, or continued pressure on the cord by unreduced bony deformity. Paralysis affected by laceration cannot be repaired. Edema of the cord can be severe enough to produce paralysis and is the most frequent and usual cause of a manometric block in the spinal fluid during the first 48 hours following injury.

The spinal cord is capable of swelling to twice its size a few moments after injury, thus instituting a complete block. There has been in the past the view that laminectomy should be done in the face of a complete block to "give the patient a last chance." In days gone by a trephine of the skull was done to relieve intracranial pressure. It was discovered that the additional trauma of the operation and the postoperative herniation were a cause of fatalities rather than a preventative thereof. Similarly the spinal cord laminectomy in cases of complete block due to edema, destroys the "patient's last chance" by adding further insult to the injury and permitting sudden herniation and permanent damage to the cord. Such cases were reported by Taylor, Scarf, et al. In one case, fully two inches of the cord was blown out in a few seconds with death resulting shortly thereafter. Hemorrhage into the cord (hematomyelia) is a frequent complication of spinal trauma. These hemorrhages occur almost exclusively within the central gray matter. The hemorrhage is usually very small and does not exert much pressure upon the longitudinal tracts which lie nearby in the white matter. The bleeding has usually ceased a few hours after the injury, and surgery can do nothing for this.

In paralysis resulting from continued pressure by fragments of bone, the spinal cord occupies only between one-third to one-half of the space in the spinal canal. Therefore, a deformity decreasing the canal at least 50% is required before injury can be affected by the actual compression from the bone. This is amply borne out by the many cases of unusual deformity in which no paralysis is evident. We must conclude that in many of those cases with paralysis the cause lies in the original injury due to laceration and hemorrhage and that the bone deformity when seen does not represent the maximum deformity at the time of the accident which may have partially reduced itself spontaneously, immediately after the injury. Laminectomy is permissible in the same type of fracture for which one still operates upon the fractured skull, that is, a fracture depressed sufficiently to threaten continued injury to the nervous tissue. It must be illustrated by means of radiographs just as in the skull that such is the case, not making random efforts to give patients a "last chance." Deformities should be corrected. This may be done satisfactorily by closed methods and operation is indicated only in rare instances. Many patients have recovered with surgery, though this may have been in spite of, rather than because of it. Surgery in spinal fractures as in skull fractures not only is ineffective but in most instances very harmful unless a depressed fragment is jutting into the canal. The usual spinal deformities are practically always reducible, early, by closed methods. Open operation increases edema by operative trauma and risks herniation of the cord and permanent paralysis in cases which may have otherwise recovered (as in skull fracture).

In closing might I call attention to the increase in malpractice suits in fracture surgery. X-rays should be taken when any doubt exists as to the severity of a back injury especially if local symptoms persist. The x-rays taken before and after reduction of any fracture belong to the physician. The possession of these radiographs are of the greatest value in discouraging any action on the part of misguided patients. Neglect to take them because of the economic situation of the injured does not lessen the physician's liability.

Miami, The Convention City



MIAMI SKYLINE AND YACHT BASIN

Miami in May will be in its gayest and most colorful mood when the members of the Florida Medical Association convene there for their annual convention at the Columbus Hotel, on beautiful Biscayne Boulevard overlooking the Bay of Biscayne.

Golfing, fishing, surf bathing, tennis, riding and yachting will provide the major forms of diversion for the Association delegates in their hours of recreation between sessions. Nine of the sportiest golf courses in the south are situated in Greater Miami. Fishing in May will be at its best in the famed tropical waters of Biscayne Bay, the gulf stream and the numerous inland waterways around Miami.

For the anglers, the sailfish, the bonito, the dolphin, and the pompano will be running, and in May stalking the wily bone fish is among the finest of sports. The jacks, tuna, marlin, and snook are other favorites plentiful in May, to mention only a few of the 600 varieties of game fish which abound in Miami's fishing grounds. Facilities for fishing are unsurpassed, whether the sportsman desires to spend a day at deep sea fishing in the gulf stream on one of the fleet of charter fishing boats under the skillful guide of veteran sea captains, or whether he prefers fishing in the bay or one of the inland streams.

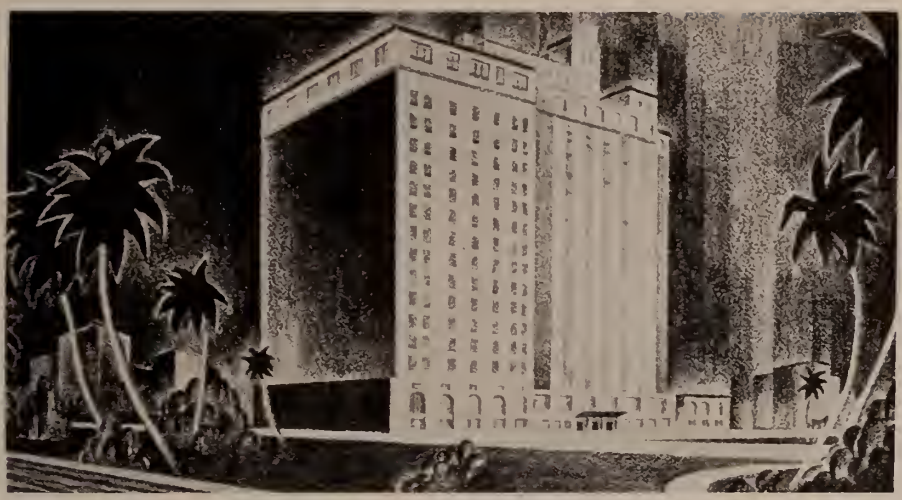
Miami's moderate year-round climate makes surf bathing and sun bathing on its miles of sun-swept beaches rank foremost in the list of diversions. Cabanas are kept open the year-round and all facilities prevailing during the height of the winter season are available for the spring and summer guests.



ONE DAY'S CATCH IN THE GULF STREAM



BATHING IS A POPULAR PASTIME, SUMMER AND WINTER



Columbus Hotel. Convention Headquarters

The yacht clubs and riding academies offer additional lures for the recreation-minded, and at night scores of smart night clubs, dining rooms and theatres make it a problem of where to spend the evening.

Distinctive among the numerous points of interest in the nation's year-round resort capital is the world's largest marine base at International Pan American Airport, where daily the huge Flying Clippers arrive and depart on romantic trips to the West Indies, Central and South America.

Palm-shaded walks lead through Bay Front park to the Miami Yacht Basin and the Royal Palm docks, where old sailing ships and modern high-power cruisers lay stem to stern, ready at a moment's notice for a refreshing trip, washed by the spindrift of a sea breeze.

Visits to the Marine Gardens under the sea may be made on glass-bottomed boats from the yacht basin, and other craft make special trips up the Miami river to the Seminole Indian villages, last remnants of pristine life in Florida.

A trip to Miami would be incomplete without a view of the intriguing Everglades along the Tamiami trail, the cypress swamps, the Seminole hunting grounds. Coral Caverns at Lost Lake, southwest of Miami, is another picturesque place, noted for its unique geological formations.

Miami has 28 municipal parks with 208 acres of tropical flowers, palm trees and shaded walks of unmatched beauty. Its 185 hotels have ample accommodations for more than 60,000 visitors.

The average year-round temperature is 75.6, and the average for May is 77, making the convention month one of the most ideal of the year. Miami has never been known to have a heat prostration, a fact of particular interest to the science of medicine.

Miami boasts an almost total absence of high humidity, and there is an average of only six days a year without sunshine. Investigations have shown that the sun's ultraviolet rays, so beneficial to health, reach Miami in greater quantity than in the famous sun resorts high in the Swiss Alps.



Tropical Setting Typical of Miami

PROGRAM

of the

SIXTY-FIFTH ANNUAL MEETING

of the

FLORIDA MEDICAL ASSOCIATION, Inc.

TO BE HELD AT MIAMI, FLORIDA

MAY 9, 10 and 11, 1938

REGISTRATION

The registration and information desks will be located in the room at the east end of the Lobby of the Columbus Hotel, with continuous service throughout the meeting. All members will be required to register and secure identification badges before attending any of the sessions. Guests and ladies are required to register. Tickets for the dinner, Tuesday evening, May 10, may be obtained at the registration desk.

HOTELS

COLUMBUS HOTEL—*Convention Headquarters*

European Plan

	Single	Double
COLUMBUS	$3.00	$5.00
Alcazar	2.50 up	4.50 up
McAllister	2.50-$5.00	4.00-$8.00
Miami Colonial	2.50- 4.00	4.00- 6.00
Ponce de Leon	2.00- 2.50	3.00- 3.50
Everglades	3.00	4.00- 6.00

TECHNICAL EXHIBITS

Technical exhibits will be located in the Lounge of the Columbus Hotel.

The technical exhibits have a real scientific value and physicians who wish to keep abreast of the times and know the latest in drugs and medical appliances should spend some time with these exhibits. It will be surprising the amount of useful information that can be procured at these exhibits. Many have nothing for sale, the representatives of the firms being there to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

The following firms have arranged for exhibits at the Miami meeting:

A. S. Aloe Company
American Optical Company
Bard-Parker Company, Inc.
Bilhuber-Knoll Corp.
H. G. Fischer & Company
C. B. Fleet Co.
General Electric X-Ray Corp.
Jones Metabolism Equipment Co.
Keleket X-Ray Co. of Florida
Lederle Laboratories, Inc.
J. B. Lippincott Company
M. & R. Dietetic Laboratories
Mead Johnson & Company, Inc.
The Wm. S. Merrell Company
The C. V. Mosby Company
Pet Milk Company
Petrolagar Laboratories, Inc.
Philip Morris & Co. Ltd. Inc.
Southeastern Optical Company
E. R. Squibb & Sons
Surgical Selling Co.
Surgical Supply Company
Westinghouse X-Ray Company, Inc.
White Belt Dairy Laboratories

SCIENTIFIC EXHIBITS

American College of Surgeons

American Medical Association

Demonstration of Fascial Planes of Urinary Extravasation by Animated Motion Pictures—James L. Estes, M. D., Tampa

Florida Radiological Society

Models of Ear Drum—James H. Mendel, M. D., Miami

Tuberculosis and Health—Florida Tuberculosis and Health Association

(Persons desiring to display scientific exhibits should write to James H. Mendel, M. D., Ingraham Bldg., Miami.)

GOLF

The Annual Handicap Golf Tournament for members of the Florida Medical Association will be played at the Miami-Biltmore Country Club on May 9 and 10.

All members of the State Association who are properly registered at the convention headquarters are eligible to compete.

Tournament play will consist of eighteen holes played May 9 or 10 at the Biltmore course. *Each contestant's handicap will be determined on the basis of the card for his tournament round.* Practice rounds are permitted, but each contestant will please signify his tournament round before it is played.

The prize list includes many articles of merchandise in addition to the rotating Orlando Handicap Cup.

Contestants in the tournament will be guests of the Biltmore Country Club unit of the Florida Year Round Club.

For additional information, communicate with Charles R. Burbacher, M. D., Chairman, Golf Committee, 227 Avenue Aragon, Coral Gables, Florida.

FISHING TRIPS

Half-day fishing trips for parties of four to six. Leave municipal piers at 8 a. m. and 2 p. m. Return at noon and 5.30 p. m. Arrangements should be made for such trips with Thomas O. Otto, M. D., Chairman, Anglers' Committee, 704 Huntington Bldg., Miami, ten days in advance of meeting.

OFFICERS OF DADE COUNTY MEDICAL SOCIETY

Arthur H. Weiland, *President*
Frazier J. Payton, *Vice-President*
Claude G. Mentzer, *Secretary*
Scheffel Wright, *Treasurer*

Local Committees

Cabinet Committee
Walter C. Jones, *Chairman*

Herman Boughton	W. Duncan Owens
C. R. Burbacher	Homer L. Pearson
H. Frank Davis	John W. Snyder
M. Jay Flipse	Robert T. Spicer
Roy J. Holmes	Joseph S. Stewart
S. D. W. Light	Harrison A. Walker
James H. Mendel	Arthur H. Weiland
James J. Nugent	Scheffel H. Wright
T. O. Otto	

Committee on Registration
Harrison A. Walker, *Chairman*

Ralph F. Allen	Taylor Lewis
W. J. Barge	Jack O. W. Rash
Gail E. Chandler	Sam J. Roberts
H. D. Eichert	Franz Stewart

Committee on Scientific Exhibits
James H. Mendel, *Chairman*

Lassar Alexander	Gerard Raap
Elmo D. French	F. C. Skilling
Rothwell Lefholz	P. B. Welch
Cayetano Panettiere	

Committee on Association Dinner
M. Jay Flipse, *Chairman*

George H. Day	C. Larimore Perry
J. Raymond Graves	James H. Putman
Eugene B. Maxwell	A. L. Walters
Bascom H. Palmer	

Committee on Smoker
Joseph S. Stewart, *Chairman*

Lee W. Elgin	E. Sterling Nichol
Jack A. McKenzie	C. E. Tumlin
Frank R. Morrow	Frank B. Voris

Committee on News
Homer L. Pearson, *Chairman*

George D. Lilly	H. A. Ryan
John T. McDonald	S. Marion Salley
Kenneth Phillips	John C. Turner

Committee on Projecting Lantern
H. Frank Davis, *Chairman*

Van M. Browne	Joseph H. Lucinian
Otto S. Dowlen	Iva C. Youmans
E. F. Fox	

Anglers' Committee
T. O. Otto, *Chairman*

John Dees	W. C. Rentz
S. F. Elder	H. B. Rogers
W. A. Haggard	M. H. Tallman
W. T. Lanier	

Committee on Golf
C. R. Burbacher, *Chairman*

Milton M. Coplan	Eugene C. Lowe
Carl E. Dunaway	Frazier J. Payton
R. M. Harris	John R. Richardson
Thomas W. Hutson	

Greeters' Committee
Herman Boughton, *Chairman*

I. H. Agos	C. F. Sayles
Roger J. Arango	C. A. Scarborough
P. L. Dodge	E. Clay Shaw
Ralph A. Gowdy	C. Kirby Smith
Charles L. Kennon	E. C. Thomas
F. E. Kitchens	Ferdinand A. Vogt
John D. Milton	Barney Weinkle

Committee on Park Program and Radio Broadcast
Roy J. Holmes, *Chairman*

E. H. Adkins	W. W. McKibben
S. P. Alderson	Warren W. Quillian
R. N. Burch	C. F. Roche
George N. MacDonell	P. T. Skaggs

Ladies' Advisory Committee
Robert T. Spicer, *Chairman*

L. A. Baker	Lucille J. Marsh
Dan Hardie	Nelson T. Pearson
Laura M. Hobbs	Jean Perdue
George N. Leonard	Wiley M. Sams
R. O. Lyell	John B. Seeds
James McClamroch	Iva C. Youmans

Finance Committee
Scheffel H. Wright, *Chairman*

R. Spencer Howell	Julius R. Pearson
Ralph W. Jack	Edward Roth
E. Norton McKenzie	Hilliard W. Willis
Claude G. Mentzer	Frank Woods
Colquitt Pearson	

Committee on Alumni and Fraternity Luncheons
James Nugent, *Chairman*

Julius Alexander	Hollis F. Garrard
H. A. Barge	M. C. Martin
B. D. Carroll	Perry D. Melvin
W. L. Fitzgerald	R. Sam Mosley

Committee on Transportation
W. Duncan Owens, *Chairman*

A. D. Amerise	Edgar Peters
Jack Q. Cleveland	E. P. Preston
J. O. Elam	J. C. Rinaman
P. J. Manson	Donald W. Smith
Max Pepper	Preston H. Watters

Clinic Committee
John W. Snyder, *Chairman*

George C. Austin	J. Randolph Perdue
E. C. Brunner	M. C. Wilson
W. T. Hotchkiss	R. C. Woodard
A. B. Litterer	

Trapshooters' Committee
S. D. W. Light, *Chairman*

E. S. Couric	E. J. Hall
M. P. DeBoe	

MONDAY

FIRST MEETING OF HOUSE OF DELEGATES

Monday, May 9, 9 A. M.
Bahama Room

President Jelks in the Chair.
Roll Call and seating of delegates.
Adoption of minutes as published in April, 1937, Journal.
Election of one delegate and one alternate to A. M. A. meeting for two-year terms.
(A. M. A. By-Laws, Chapter 1, Sec. 1: "A member of the House of Delegates must have been a member of the American Medical Association and a Fellow of the Scientific Assembly for at least two years next preceding the session of the House of Delegates at which he is to serve.")
Reading of Resolutions.
Recommendations of Executive Committee.
Reports of Committees:
Report of Council Chairman, W. McL. Shaw.
Legislation and Public Policy, Julius C. Davis.
Medical Education and Hospitals, Leland F. Carlton.
Publication, Walter C. Jones, Jr.
Public Relations, J. Ralston Wells.
Necrology, George W. Potter.
Medical Postgraduate Course, T. Z. Cason.
Cancer Control, F. Clifton Moor.

Medical Economics, J. C. Vinson.
Venereal Disease Control, E. T. Sellers.
Inter-Relationship, William M. Rowlett.
Tuberculosis and Public Health, M. Jay Flipse.
State Controlled Medical Institutions, H. Mason Smith.
Maternal Welfare, Homer L. Pearson.
Child Health, Luther W. Holloway.
Advisory to Woman's Auxiliary, Gordon H. Ira.
Delegates to A. M. A., Herbert L. Bryans and Meredith Mallory.
Other Committees.
New Business.
Next Year's Meeting Place (*on recommendation, Executive Committee*).
Announcements.
Adjournment.

CLINICS

JACKSON MEMORIAL HOSPITAL, Miami
Monday, May 9, 9 A. M. to 12 Noon

1. Tuberculosis Service will demonstrate pneumolysis and pneumothorax procedures. Presentation of cases.
2. Medical Service will present electrocardiography, diabetes, and other unannounced subjects.
3. Dermatological Service will present and discuss varied types of skin lesions.
4. Surgical Service will conduct operative clinic in orthopedics, bronchoscopy, surgery of the eye, gynecology, thyroid surgery, thoracoplasty and phrenic exeresis, gastric surgery.

Five operating rooms will be used for these clinics.
Luncheon at Hospital.

ST. FRANCIS HOSPITAL, Miami Beach
Monday, May 9, 9 A. M. to 12 Noon

Demonstration of physiotherapy and hydrotherapy as conducted by this institution.
All operations of the morning will be open to visiting physicians.
Luncheon at Hospital.

FIRST GENERAL SESSION

Monday, May 9, 1:30 P. M.
ASSEMBLY ROOM—17TH FLOOR

Call to Order, President Edward Jelks.
Invocation, Dr. R. Z. Tyler, Pastor Trinity M. E. Church, South, Miami.
Address of Welcome, Hon. Robert R. Williams, Mayor, Miami.
Address of Welcome, Arthur H. Weiland, M. D., President Dade County Medical Society.
Introduction, Delegates from other State Societies:
Wm. Willis Anderson, Atlanta.
William R. Dancy, Savannah.
T. C. Davison, Atlanta.
Arthur G. Fort, Atlanta.
New Business.
Announcements.

SCIENTIFIC ASSEMBLIES

Committee on Scientific Work: Leigh F. Robinson, Ft. Lauderdale; Roscoe H. Knowlton, St. Petersburg; John S. McEwan, Orlando; Harry F. Watt, Ocala; Carol C. Webb, Pensacola; Herbert E. White, St. Augustine.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the Secretary when read."

"No address or paper before the Association, except those of the President and Orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject."

PROJECTORS

The Committee on Projecting Lantern has arranged for a projecting lantern and daylight screen and also a moving picture projector for use during the convention. An operator will be available at all times. Essayists wishing to illustrate their papers with lantern slides or moving picture films should communicate with Dr. H. Frank Davis, 1009 Huntington Building, Miami, chairman of the committee in charge.

FIRST SCIENTIFIC ASSEMBLY

Monday, May 9, 2:30-5 P. M.
ASSEMBLY ROOM — 17TH FLOOR

1. "Preoperative and Postoperative Care in Intestinal Obstruction", Harrison A. Walker, Miami Beach.
   Various types of intestinal obstruction, including their causes. Importance of the blood chemistry picture. Immediate operation advisable in certain cases; in others, decompression and building up of blood chemistry.
   Discussion: Lloyd J. Netto, West Palm Beach; Edward Jelks, Jacksonville.
2. "Quinine Blindness in Children", Luthur W. Holloway, Jacksonville.
   Malarial fever occurs endemically in certain areas of Florida. Many patients receive quinine therapy on presumption of the existence of malarial infection. Some physicians prescribe quinine in many febrile conditions. Report of four cases of permanent eye disability in children to whom quinine had been administered although no malarial infection existed.
   Discussion: Bascom H. Palmer, Miami; Shaler Richardson, Jacksonville.
3. "Hand Infections" (lantern slides), Carol C. Webb, Pensacola.
   Review of anatomy, etiology, bacteriology; elective sites of drainage; treatment in connection with these injuries.
   Discussion: Julius C. Davis, Quincy; Samuel F. Elder, Miami.
4. "Frequent Causes of Prolonged Disability in Fracture Treatment" (lantern slides), M. Paul Travers, Miami.
   Over-immobilization, under-immobilization. Care of the hands in fractures of the upper extremities. Postoperative neglect. Limitations of physiotherapy.
   Discussion: Ferdinand A. Vogt, Miami; Edward M. Cullipher, Miami.

PUBLIC MEETING, BAY FRONT PARK

Monday, May 9, 7:30 P. M.

Music.
Speaker—
Dr. Warren F. Draper, Asst. Surgeon General, U. S. Public Health Service, Washington, D. C.

LADIES' AND GENTLEMEN'S SMOKER

Monday, May 9, 9:30 P. M.
CORAL GABLES COUNTRY CLUB
(Informal)

Dancing—Games for Young and Old—Slave Market for Unattached Men—Refreshments—Floor Show.

TUESDAY

SECOND SCIENTIFIC ASSEMBLY

Tuesday, May 10, 9-11 A. M.
ASSEMBLY ROOM — 17TH FLOOR

5. "Insulin Shock Therapy", A. L. Huskey, Chattahoochee.
   Treatment at Florida State Hospital; technique followed; results of cases at Florida State Hospital; future of therapy; conclusions.
   Discussion: W. Henry Spiers, Orlando; H. Mason Smith, Tampa.

6. "The Relationship of Carcinoma of the Larynx to Precancerous Lesions" (lantern slides), R. E. Repass and C. S. McLemore, Miami Beach.
Brief historical review of the English literature. Incidence; ratio of male to female. Diagnosis. Treatment; operation of choice for intrinsic carcinoma of vocal cords. Complications; MacKenty's cases. Prognosis; Sir St. Clair Thomson and Chevalier Jackson's statistics. Presentation of case.
Discussion: H. Marshall Taylor, Jacksonville; Joseph W. Taylor, Tampa.

7. "Management of Sinusitis" (lantern slides), Orville N. Nelson, Bay Pines.
Brief review of development of the common cold and sinusitis. Conservative measures which can be carried out with good results by the general medical practitioner and the specialist. Operative procedures when conservative medical treatments fail.
Discussion: J. M. Ingersoll, Miami; Roncie R. Duke, Tampa.

SECOND GENERAL SESSION

Tuesday, May 10, 11 A. M.

Assembly Room—17th Floor

Call to Order, Edward Jelks, President.
Reports of Officers and Committees:
Secretary-Treasurer-Editor, Shaler Richardson, and Managing Director, Stewart Thompson.
Executive Committee, Gilbert S. Osincup.
President's Address, Edward Jelks, Jacksonville.

THIRD SCIENTIFIC ASSEMBLY

Tuesday, May 10, 2-5 P. M.

Assembly Room — 17th Floor

8. "Diagnosis and Treatment of Amebic Dysentery", James L. Borland, Jacksonville.
Description of organisms and differentiation from other protozoa. Incidence in Florida. Clinical picture with particular reference to the temperate zone; its clinical differential diagnosis; methods of examination; drug used in treatment; complication and subsequent course, with special attention to handling of post-treatment symptoms.
Discussion: W. McL. Shaw, Jacksonville; Ralph N. Greene, Coral Gables.

9. "Presacral Nerve Resection for the Relief of Pelvic Pain" (motion pictures), John R. Boling, Tampa.
Type of lesion in which presacral resection is indicated. Technique of operation. Report of cases. Motion pictures showing operation.
Discussion: William M. Rowlett, Tampa.

10. "Disturbances of Cardiac Rhythm" (lantern slides), S. Marion Salley, Miami.
Clinical diagnosis and treatment of the more important cardiac arrhythmias. Too much dependence on electrocardiography has caused neglect of clinical approach to these problems. Diagnosis of many "perplexing" arrhythmias without the aid of electrocardiograph.
Discussion: R. S. Torbett, Tampa; Louie M. Limbaugh, Jacksonville.

11. "Prefrontal Lobotomy for Involutional Melancholia" (lantern slides), J. G. Lyerly, Jacksonville.
Operation consists of subcortical section of association fibres in both prefrontal lobes. Its efficacy is based on the results obtained in mental and personality changes following lobectomy for tumor and Fulton's experimental work on apes. These results show pronounced improvement and probable cure of such symptoms as severe depression, anxiety, apprehension, worry, and nervous tension. Report of cases.
Discussion: William H. McCullagh, Jacksonville; Ralph E. Stevens, Chattahoochee.

12. "The Final Responsibility of Public Health Rests on the Medical Profession", A. B. McCreary, Jacksonville.
The responsibility and control of public health belongs to the medical profession. Comparison shows that the most efficiently operated health departments are under the direct control of the medical profession. Public health activities should be confined in scope to educational, advisory, investigatory, and legal. Prevention, not treatment. The best interest of the public as well as the profession can be advanced through health education promulgated by an adequate health service.

SECOND MEETING OF HOUSE OF DELEGATES

Tuesday, May 10, 5 P. M.

Bahama Room

Unfinished Business.

ASSOCIATION DINNER

Tuesday, May 10

Columbus Hotel—17th Floor

7:30 P. M. Dinner. Short talks by Edward Jelks, President; W. Henry Spiers, President-elect; Arthur H. Weiland, President, Dade County Medical Society. Dr. T. O. Otto introducing Dr. J. M. T. Finney, Guest Speaker.

10:00 P. M.-2 A M. Dancing.

Dinner tickets ($3.00) may be obtained at the registration desk.

WEDNESDAY

FOURTH SCIENTIFIC SESSION

Wednesday, May 11, 9-11 A. M.

Assembly Room — 17th Floor

13. "Lupus Erythematosus" (lantern slides), Lauren Sompayrac, Jacksonville.
Brief history of a chronic disfiguring skin disease that occurs on the exposed parts of the skin, quite frequently seen in Florida due to sunlight. In years gone by, designated as tuberculid. Pathological research has uncovered the fact that focal infection is oftentimes the cause of the chronic, erythematous scaly skin condition. Treatment.
Discussion: J. L. Kirby-Smith, Jacksonville; Elmo D. French, Miami.

14. "Adolescent Turmoil: Agitated Depression with Panic Reaction", Jess V. Cohn, Hollywood.
Demonstration of relationships among the endocrine, sympathetic nervous and psychomotor systems. Importance of keeping an open mind when behavior disturbances, as chief complaints, are encountered. The "why" of our conduct is the sum-total of the type of harmony among the various integrated systems of the body. Case history which illustrates method of investigation.
Discussion: William H. McCullagh, Jacksonville; Elliott M. Hendricks, Ft. Lauderdale.

15. "Sterility", C. D. Hoffmann, Orlando.
Definition; primary, secondary or acquired. Examination of patient; complete history referable to illnesses, infections, previous childbirths, operations, etc. Routine plan of examination, including: basal metabolic test; blood and laboratory; pelvic findings; Rubin tests, technic and interpretation of results; Hille or Huhner tests, examination of sperm; transplantation of semen, technic; ovulation stimulation with various hormones; operative repair of obstructed tubes with percentage of favorable results; lipiodol injections and x-ray diagnosis.
Discussion: Horace A. Day, Orlando; John D. Milton, Miami.

THIRD GENERAL SESSION

Wednesday, May 11, 11 A. M.

Assembly Room, 17th Floor

President Jelks in the Chair.
Address by Guest of Honor, J. M. T. Finney, Emeritus Professor of Surgery, Johns Hopkins University, Baltimore.
Unfinished Business.
New Business.
Election of President-elect.
Election of First Vice-President.
Election of Second Vice-President.
Election of Third Vice-President.
Election of Secretary-Treasurer and Editor of Journal.
Dr. W. Henry Spiers escorted to the Chair as new President.
Presentation of Past-President's Button to Dr. Edward Jelks.
Adjournment.

FLORIDA RAILWAY SURGEONS' ASSOCIATION

OFFICERS

J. Ralston Wells, President ..... Daytona Beach
A. R. Beyer, Vice-President ..... Tampa
H. D. Clark, Secretary-Treasurer ..... Fort Pierce

COMMITTEES

Executive

Leland F. Carlton, Chairman ..... Tampa
T. M. McDuffee ..... Manatee
T. M. Rivers ..... Kissimmee

Scientific

T. H. Bates, Chairman ..... Lake City
E. B. Hardee ..... Vero Beach
M. P. DeBoe ..... Miami

Necrology

Frederick J. Waas, Chairman ..... Jacksonville
Henry E. Palmer ..... Tallahassee
R. O. Lyell ..... Miami

Local Committee on Arrangements

R. O. Lyell, Chairman ..... Miami
S. D. W. Light ..... Miami
R. C. Woodard ..... Miami

OPENING SESSION

Monday, May 9, 9:30 A. M.

COLUMBUS HOTEL, 17TH FLOOR

Call to Order, J. Ralston Wells, President.
Invocation.
Address of Welcome.
Minutes.
Reports of Committees.
President's Address.

SCIENTIFIC PROGRAM

10 A. M.

Papers limited to fifteen minutes each. Discussion in total limited to fifteen minutes.

Guest Speaker, Glen I. Jones, Chief Surgeon, Southern Railway, Washington, D. C.

1. "Foreign Bodies of the Cornea, their Removal and Subsequent Treatment," C. E. Dunaway, Miami.
2. "Treatment of Traumatisms of the Chest," Herman Watson, Lakeland.
3. "Abdominal Injuries," Harold D. Van Schaick, Jacksonville.
4. "Treatment of Fractures of the Neck of the Femur by Internal Fixation," Frank D. Gray, Orlando.

BUSINESS MEETING

Election of Officers and Induction into Office.
Announcements.
Adjournment.

REGULAR QUARTERLY MEETING OF THE FLORIDA SOCIETY OF DERMATOLOGY AND SYPHILOLOGY

OFFICERS

President, Chadbourne A. Andrews ..... Tampa
Secretary, Lauren Sompayrac ..... Jacksonville

Sunday, May 8, 9 A. M.

CITY CLINIC BLDG.

Elmo D. French, *Chairman*

Clinical Session.
Business Meeting.
Election of Officers.
Luncheon for Visiting Dermatologists.

FLORIDA SECTION SOUTHEASTERN SURGICAL CONGRESS

Monday, May 9, 11 A. M.

ROOM 524

Business Meeting.

THIRD ANNUAL MEETING OF THE FLORIDA PEDIATRIC SOCIETY

OFFICERS

President, Douglas D. Martin ..... Tampa
Secretary-Treasurer, Warren Quillian ..... Coral Gables

DINNER MEETING

Sunday, May 8, 8 P. M.

COLUMBUS HOTEL, BAHAMA ROOM

Toastmaster, Douglas D. Martin, President, Florida Pediatric Society.
Guest Speaker, Edward Clay Mitchell, Regional Chairman, American Academy of Pediatrics, Memphis.
Round Table Discussion.
Business Meeting.
Election of Officers.

PROGRAM OF THE SEVENTH ANNUAL SPRING MEETING OF THE FLORIDA RADIOLOGICAL SOCIETY

OFFICERS

President, Gerard Raap ..... Miami
Vice-President, Harold O. Brown ..... Tampa
Secretary, H. B. McEuen ..... Jacksonville

COLUMBUS HOTEL, ROOM 510

Sunday, May 8

10:00 A. M. Round table discussion and exhibit of films.
2:00 P. M. Round table discussion and exhibit of films.

ROOM 510

Monday, May 9

10:00 A. M. Therapy discussion.
11:30 A. M. Election of officers.

PROGRAM FOR WOMEN

LOCAL COMMITTEE CHAIRMEN

President, Woman's Auxiliary, Dade County Medical Society, Mrs. R. O. Lyell.
General Chairman, Mrs. W. T. Lanier; Assistant, Mrs. E. P. Preston.
Hospitality, Mrs. Gerard Raap.
Registration, Mrs. W. J. Barge.
Transportation, Mrs. Frank Morrow; Assistant, Mrs. Scheffel Wright.
Finance, Mrs. H. A. Leavitt.
Luncheon, Mrs. Jack McKenzie.
Flowers, Mrs. James McC'amroch.
Publicity, Mrs. H. A. Barge.

Monday, May 9

4:00 P. M.—Executive Board Meeting, Bahama Room, Columbus Hotel.

9:30 P. M.—Entertainment and Dance, Coral Gables Country Club.

Tuesday, May 10

9:30 A. M.—General Auxiliary session, Columbus Hotel, Bahama Room, followed immediately by a post-convention Board meeting.

12:30 P. M.—Luncheon at Roney Plaza Hotel, followed by Sightseeing boat trip on Biscayne Bay.

7:30 P. M.—Association Dinner, Columbus Hotel, 17th floor.

Wednesday, May 11

Motorcade, visiting points of interest in Greater Miami area.

Florida Medical Association, Inc.

Officers and Committees

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(Terms expire after A.M.A. meeting, 1937)

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J. M. T. FINNEY, M. D., OUR HONOR GUEST

Doctor John Miller Turpin Finney was born in 1863, in Natchez, Mississippi. His father was the Reverend Ebenezer D. Finney, a Presbyterian Minister, who had gone South from Maryland before the War.

Dr. Finney was educated at Princeton University, where he graduated in 1884, and from the Harvard Medical School in 1889. He afterwards served a term as surgical intern at the Massachusetts General Hospital in Boston leaving there to join the staff of the Johns Hopkins Hospital when it opened in 1889. He was later Associate in Surgery, Associate Professor of Surgery and Surgeon-in-Chief to the Johns Hopkins Hospital, and Professor of Clinical Surgery and Professor of Surgery in the Johns Hopkins University, where he is now Emeritus Professor of Surgery.

Doctor Finney was one of the Founders and the First President of the American College of Surgeons. He entered the Army at the beginning of the World War, with the rank of Major, in the Reserve Corps. He went to France as Director of Base Hospital No. 18; was promoted later as Colonel and Brigadier General, and was Chief Consultant in Surgery in the A. E. F. He received the Distinguished Service award in the U. S. A., and decorations from Belgium and France.

He is a member and former President of the American Surgical Association, and the Southern Surgical Association; a Fellow of the Southern Medical Association; member of the Royal College of Surgeons of England and Edinburgh; and an Honorary member of the Medical Society of London and the Hunterian Society. He is a member of the Board of Trustees of Princeton University, and the State Board of Education of Maryland and other educational institutions.

Doctor Finney was recipient of the Bigelow Medal in '32. He received Honorary Degree of LL.D. from Tulane University in '35, and Harvard in '37.

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A DISTINCTIVE ACHIEVEMENT

The annual Short Courses are "the most distinctive achievement of the Florida Medical Association," according to our President, Dr. Edward Jelks. Doctor Jelks is in a position to judge, moreover, having attended all of the five courses previously offered.

In the opinion of the Postgraduate Course Committee and those with whom they have had the opportunity to discuss their plans, the Short Course this year will uphold the reputation previously made. Because they were so popular with the men attending the course, several of the instructors were invited to return this year. Those who have consented to come are Dr. W. Emory Burnett of Philadelphia, who will present the course in Surgery; Dr. J. O. Arnold, also of Philadelphia, who will give the lectures on Obstetrics; and Dr. Alexander J. Schaffer of Baltimore, whose lectures on Pediatrics were so well received last year.

New names on the roster of instructors are those of Dr. R. J. Crossen of St. Louis, who will present the Gynecology course; Dr. Maurice C. Pincoffs of Baltimore, who will give the lectures in Medicine; and Dr. Beverly Tucker of Richmond, who will conduct the lectures in Neuropsychiatry.

As previously announced, Daytona Beach has been selected for the meeting place this year. The dates are from June 27 through July 2. All sessions will be held at the Osceola Hotel. Inasmuch as the hotel is making attractive rates, this will be a great convenience to physicians attending.

Detailed information concerning the Short Course will be published in the next issue of the Journal. Watch for it.

NOTICE TO DELEGATES AND COMMITTEE CHAIRMEN

The first meeting of the House of Delegates will be held Monday morning, at 9 o'clock on May 9 at the Columbus Hotel in the Bahama Room. The entire forenoon Monday, if necessary, will be devoted to important matters for action of the House of Delegates. Reports of standing committees will be read at this first meeting of the House of Delegates. Chairmen of standing committees are urged to be present on time in order that their reports may follow the published schedule on the program. The House of Delegates is one of the important sessions of the annual convention. In order that there may be a convenient time for this important meeting, Monday forenoon has been designated so that the business to be taken up may be carefully considered. Delegates and committee chairmen are urged to note the date and the time of the first meeting of the House of Delegates—9 a. m., Monday, May 9.

CONVENTION NOTES

THE MIAMI CONVENTION

To the Editor:

When the invitation was presented to the House of Delegates to have our Convention in Miami this year, I was none too sure that we could put on as good a Convention as they did in St. Petersburg, but as the time approaches for the meeting and as plans take form, there is no longer any doubt about it. We are ready to give the Florida Medical Association the greatest Convention in its history. It is our plan to have all those who attend, leave here so exhausted from having a good time, that they will have to take another week off to rest up. We want, and plan, this meeting to be so big that for years to come it will still be the Association's greatest Convention.

We have a Greeters Committee, that will really "GREET." The trains, boats, planes, buses, and cars will be met and when the men get to Miami they will know that they have arrived and that the Convention is now in progress.

We have arranged clinics at the Jackson Memorial and St. Francis Hospitals for Monday morning, May 9. There will be medical, surgical and fracture clinics for all those who wish to see them. Luncheon will be served at the hospitals.

We are planning a new wrinkle in the Smoker. Instead of being a Stag Smoker as in previous years, we plan to have a regular night club party for all the doctors and their wives, with lots of entertainment and dancing and much fun for everybody. In other words we are doing the unheard of thing of *inviting the ladies to the Smoker,* and I know they will like that. We are expecting about eight hundred to attend that party and it will be held at the Coral Gables Country Club, Monday night.

At the Association Dinner to be held Tuesday night, we will only try to equal the one at St. Petersburg, with this improvement; the dance orchestra will not stop at twelve o'clock, but will play until 2:00 A. M., at least.

The Golf Tournament will be the best ever held. There will be prizes for everyone and it will be held at the Biltmore Country Club. The Club has been very generous in letting us use its course, which is the best in Miami, without any charge for greens fees. There will also be a new method for determining a golfer's handicap, that will be interesting.

We are planning many other interesting features, including sightseeing trips, fishing, trapshooting, etc.

There will be a gala public meeting in the Bay Front Park with music and a nationally known speaker.

Our Woman's Auxiliary has planned a very complete and interesting three days for the visiting ladies, and if the ladies don't attend this Convention, they will forever be sorry. There will be interesting boat trips, motorcades, luncheons and parties. They can't afford to miss it.

In short, we are expecting a capacity attendance and are prepared for it.

Homer L. Pearson, M. D.
Chairman of Committee on News.

CLINICS

To the Editor:

The Committee on Clinics is arranging a program for the meeting of the Florida Medical Association, which will be varied sufficiently to be of interest to most men. We expect to have all clinics running simultaneously between the hours of 9 a. m. and 12 noon on the morning of May 9. That is, the clinics will be held Monday forenoon, preceding the first afternoon session.

The Jackson Memorial Hospital will present clinics as follows: demonstration of pneumolysis and pneumothorax procedures; electrocardiography, and diabetes; various types of skin lesions; operative clinics in orthopedics, bronchoscopy, surgery of the eye, gynecology, thyroid surgery, thorocoplasty and phrenic exeresis, gastric surgery. Five operating rooms will be utilized.

The St. Francis Hospital of Miami Beach will be pleased to demonstrate physiotherapy and hydrotherapy as conducted in that institution. In addition, all operations of the morning will be open to visiting physicians.

We hope that our program will be found to be of sufficient interest to inspire an extra effort on the part of our members so that they may be on hand a few hours earlier and help put the clinics over with enthusiasm.

J. W. Snyder, M. D., *Chairman, Committee on Clinics.*

LADIES INVITED TO ANNUAL SMOKER

To the Editor:

At every annual medical meeting the men step out for their stag affair while the ladies stay behind impatiently awaiting the stories of new oddities that have taken place.

Why do the smokers always break up so early? They do, don't they?

An innovation! This year the ladies are invited to attend the annual smoker.

Dancing, side shows, food, free beer, the best show the Miami area can assemble; shows for men only, shows for ladies only, bridge,

jokes on many, singing, goodfellowship, dancing, and so on far into the night.

If this mixed smoker breaks up as early as previous smokers your committee will know the men love their nights out but if it lasts to the wee small hours it will be your vote for a good time.

Bachelors—don't worry—there will be a slave market. The entertainment will take care of men and women from seventy to eighty, sixty to seventy, fifty to sixty, forty to fifty, but all younger or older will have to look out for themselves.

Come, you men and women, but leave all care behind! Come, you women, that you may see what an annual Smoker is like and that you may teach your men that fun is a partnership affair. Come you men that you may prove that at a Smoker, play makes the Doctor young; makes it possible to practice this ever serious and nerve depleting medicine.

And ladies, won't you come to see your husbands at play; won't you, too, play? Let's all be young for the night.

Jos. S. Stewart, M. D., *Chairman, Committee on Smoker.*

ALUMNI AND FRATERNITY LUNCHEONS

The local committee has made comprehensive plans for meetings during the Miami Convention. The name of the school and fraternity of every member of the Dade County Society has been obtained and lists are available. Extremely interesting is the fact that many friends of long standing are only now learning that they are fraternity brothers or school mates. In order that the members of the state association may be identified, each doctor will be asked to signify his school and fraternity when registering for the Convention. Complete lists of classification will be posted at the registration desk. Members of the committee will assist the Greeter's Committee and will give personal invitations to each visiting doctor to attend his respective group luncheon. The committee will arrange for meeting places for all groups which desire to gather. At the present time twenty-two fraternities and schools have signified their desire to meet together. The list, together with the committeeman in charge of introductions follows:

Emory University.....Sam Mosley
University of Georgia.....Lynn Whelchel
Indiana University.....E. W. Cullipher
University of Illinois.....S. P. Alderson
Jefferson Medical.....Gail E. Chandler
Johns Hopkins.....Ralph W. Jack
University of Louisville.....H. W. Willis
University of Maryland..Herbert D. Eichert
University of Michigan.....Wiley Sams
St. Louis University.....Nelson Pearson
University of Tennessee.....Edward F. Fox
Tulane University
W. L. Fitzgerald, J. Alexander
Vanderbilt University.....B. D. Carroll
University of Virginia..J. Randolph Perdue
Alpha Kappa Kappa.....Perry Melvin
Nu Sigma Nu.....George D. Lilly
Alpha Omega Alpha.....Ralph Allen
Phi Beta Pi.....H. A. Barge, W. J. Barge
Phi Chi.....Hollis Garrard
Phi Delta Epsilon.....S. Charles Werblow
Phi Rho Sigma.....Roger Arango
Theta Kappa Psi.....James H. Putman

It is expected that other groups will wish to have meetings and the committee will be pleased to make arrangements when notified. All luncheons will be "Dutch Treat" and every group will be provided for if sufficient interest is evidenced. The purpose of this article is to stimulate such requests. Address your letter to James J. Nugent, 303 Ingraham Building, Miami, Florida.

FISHING

The Anglers' Committee is arranging fishing trips in the ocean for a half day's duration, without any expense to those who indulge, provided, however, that the chairman of the committee be notified by May 1. The committee proposes to have boats available at the municipal piers and to take out parties, four to six in number, boats to leave at 8 a. m. and return at 12 noon. The afternoon schedule has boats leaving at 2 p. m. and rereturning at 5:30 p. m. It is very important that the Anglers' Committee obtain the approximate number of doctors who propose to fish. If you are interested in making one of these fishing trips, notify Dr. Thomas O. Otto, Chairman of the Anglers' Committee, 704 Huntington Building, Miami.

PROGRAM OF SPRING MEETING FLORIDA MIDLAND MEDICAL SOCIETY

Orlando, April 28, 2 p. m.

COLONIAL ORANGE COURT HOTEL

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BUSINESS SESSION

Meeting called to order by the President.
Reading of Minutes of Fall Meeting.
Report of Committees.
New Business.

SCIENTIFIC SESSION

2:15 p. m.

"Common Fractures About the Wrist"
EUGENE L. JEWETT, Orlando
Discussion: J. W. ALSOBROOK, Plant City

"Cardiology in Aviation"
A. J. BIEKER, St. Petersburg
Open Discussion.

"The Common Cold and Some of its Complications"
J. A. STRICKLAND, St. Petersburg
Discussion: R. S. TORBETT, Tampa

"Injection Treatment of Hernia"
PAUL T. BUTLER, Orlando
Discussion: T. H. ROBERTS, Lakeland

(15 minute recess)

"The State Tuberculosis Sanatorium: Its Relationship to the General Practitioner; Modern Therapy and Methods of Treatment"
R. D. THOMPSON, Orlando
Discussion: ARNOLD S. ANDERSON, St. Petersburg

"Vaginal Hysterectomy"
JAMES M. BRYANT, Jacksonville
Discussion: JOHN R. BOLING, Tampa

"Fasciotomy—Ober Operation for Lame Back and Sciatic Pain".....C. S. FRANCKLE, St. Petersburg
Discussion: ALEXANDER KUSHNER, Venice

"The Use of Alum in the Control of Gastric and Duodenal Hemorrhage"...J. A. MEASE, JR., Dunedin
Open Discussion.

"Malignancies of the Gastro-Intestinal Tract"
JOHN N. MOORE, Ocala
Discussion: HAROLD O. BROWN, Tampa

DINNER MEETING

COLONIAL ORANGE COURT HOTEL
7:30 p. m.

Guest Speaker, NEWDIGATE M. OWENSBY, Atlanta
Subject:
"Modern Concepts and Treatment of Mental Illness"

ADDITIONAL DELEGATES AND ALTERNATES ELECTED BY COMPONENT SOCIETIES TO THE ANNUAL MEETING IN MIAMI, 1938

(Supplementing List Published in March Journal)

The number of delegates to be seated from any one component society will be one for each twenty members who have paid 1938 dues and one for each major fraction thereof.

COLUMBIA COUNTY MEDICAL SOCIETY

ROBERT B. HARKNESS.....Lake City
HARRY S. HOWELL.....Lake City

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WASHINGTON-HOLMES COUNTY MEDICAL SOCIETY

GEORGE W. CARTER.....Caryville

STATE NEWS ITEMS

Dr. C. E. Tumlin of Miami attended the meeting of the International College of Surgeons of Geneva (Southern Assembly, Florida, Georgia, Alabama, Louisiana and Mississippi), held at the Tampa Municipal Hospital, February 28.

* * *

Dr. Blanche A. Burgner of Sarasota announces the removal of her offices to 226 Park Street.

* * *

Dr. Charles B. Mabry and Miss Alva Davis, both of Jacksonville, were married on March 11.

The Seaboard Air Line Railway has set up a special itinerary for the movement to San Francisco where the convention of the American Medical Association will be held June 13-17 and you will note its advertisement appears in this issue, in which an itinerary has been suggested by Dr. Herbert L. Bryans of Pensacola.

* * *

Dr. Kenneth Phillips and Dr. A. B. Litterer of Miami left for New York the first of April, where they will give a paper entitled "Five Years' Experience With Fever Therapy in Syphilis" before the American College of Physicians.

* * *

Dr. T. F. Hahn of DeLand was recently elected to Associate Membership in the American College of Physicians.

* * *

Dr. S. G. Hollingsworth of Bradenton was recently reappointed by Governor Cone to the State Board of Medical Examiners for a term of four years, ending July 31, 1941.

* * *

Dr. Young C. Lott of Miami announces the removal of his offices to the Olympic Building.

* * *

At the annual election of the Victoria Hospital, Miami, held in January, the following officers were chosen: President, Dr. Rothwell Lefholz; Vice President, Dr. James J. Nugent; Secretary, Dr. A. Buist Litterer; Executive Committee, Drs. John W. Snyder, Thomas O. Otto and P. B. Welch.

* * *

The radio broadcasts of the American Medical Association during the coming month will feature "Mothers and Children." These programs, which are broadcast at 2:30 p.m., will be as follows:

Apr. 27—Healthier Babies. Daily routine of the healthy baby; medical supervision; feeding.

May 4—Healthier Mothers. General advice for the expectant mother; good for boys and girls to know about.

May 11—Hospitals Aid Health. The place of the hospital in the health program of the individual and the community.

May 18—Runabouts, 1938 Model. The preschool child and the health and personality problems of that age.

Dr. John T. Macdonald of Miami has moved his offices to 810-811 Ingraham Building.

* * *

Dr. and Mrs. C. J. Collins of Orlando announce the birth of a son, Michael, on December 4, 1937, at the Orange General Hospital.

* * *

Dr. C. C. Mendoza of Jacksonville was a guest of the Seminole County Medical Society at its meeting in February, where he demonstrated the latest method of indirect blood transfusion.

* * *

Dr. and Mrs. Arthur H. Weiland of Coral Gables announce the birth of a daughter, Judith Susan, on February 23, at Jackson Memorial Hospital.

* * *

Dr. Davis Forster of New Smyrna, died on March 23, 1938, at Bay Pines.

* * *

The first meeting of the House of Delegates will convene at 9 a. m. Monday, May 9. All delegates please remember the time, Monday morning at 9 a. m.

* * *

Dr. Walter D. Webb of St. Augustine has announced his candidacy for representative in the Florida Legislature from St. Johns County, running in Group 1.

* * *

Dr. R. R. Killinger of Jacksonville was recently elected president of the Atlantic Coast Line Railroad's Association of Surgeons, at a meeting held in St. Petersburg. Dr. L. M. Gable of St. Petersburg is a vice-president of the organization.

* * *

Dr. C. D. Cleghorn of Miami died on March 26, after a long illness. He was one of the leading radiologists of Miami, having practiced in that city for the past twelve years.

* * *

Dr. Edward Jelks of Jacksonville, president of the Association, addressed the DeLand Woman's Club at an open meeting on April 12. His subject was "The True Meaning of Organized Medicine and its Part in Safeguarding the Public Health."

Dr. Joseph L. Chilli of Jacksonville recently announced his candidacy for membership on the Duval County Board of Public Instruction.

WANTED: Location, position, or connection in Florida by Wisconsin physician holding Florida license. Competent and reliable. Age 32; eight years' experience in general practice plus refraction. Would consider locum tenens. Can arrange for personal interview in June. Please furnish complete details. Address No. 5574, care of Journal.

* * *

COMPONENT COUNTY SOCIETIES

BREVARD COUNTY MEDICAL SOCIETY

THE BREVARD COUNTY MEDICAL SOCIETY STANDS 100% PAID FOR 1938. BECAUSE THE MEMBERS OF THIS SOCIETY ARE LOCATED IN FIVE CITIES, THIS ACHIEVEMENT BECOMES MORE NOTEWORTHY. DR. G. E. CHRISTIE IS PRESIDENT OF THE SOCIETY, DR. W. J. CREEL IS VICE-PRESIDENT AND DR. I. K. HICKS IS SECRETARY-TREASURER.

* * *

BROWARD COUNTY MEDICAL SOCIETY

THE BROWARD COUNTY MEDICAL SOCIETY, WITH A MEMBERSHIP OF 31 HAS JOINED THE SOCIETIES WHOSE DUES ARE 100% PAID FOR 1938. DR. A. B. CONNOR IS PRESIDENT OF THE SOCIETY; DR. R. E. BLOUNT, VICE-PRESIDENT; AND DR. O. C. BROWN, SECRETARY-TREASURER.

* * *

DADE COUNTY MEDICAL SOCIETY

The regular meeting of the Dade County Medical Society was held in the Assembly Room of the Florida Power & Light Company on the evening of March 1. Dr. Arthur H. Weiland, president, presided.

The scientific program consisted of two papers: "A Brief Discussion of a Vital Pediatric Problem" by Warren Quillian, and "Pneumonia" by Herman Boughton. Both papers drew lively discussion.

The following doctors were elected to serve as delegates and alternates at the coming convention of the State Association: Joseph Stewart, M. Jay Flipse, Walter Jones, Arthur H. Weiland, Milton M. Coplan, Homer L. Pearson, Scheffel Wright, Elmo D. French, Duncan Owens, Robert Spicer, Herman Boughton, R. N. Burch, S. Marion Salley, Carl Dunaway, Roy J. Holmes, Gerard Raap, Warren Quillian, Claude Mentzer, W. W. McKibben, T. O. Otto, P. B. Welch, Lee Elgin, J. M. McClamroch, John Milton, Frank Morrow, Harrison A. Walker, I. H. Agos, Thomas W. Hutson, and Bascom H. Palmer.

* * *

DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society held its regular meeting on the evening of April 5 in the Library of the State Board of Health. The scientific program consisted of a symposium on "Deficiency Diseases," presented as follows:

"Certain Observations upon Vitamin Deficiencies"—W. W. Kirk.

"Intrinsic Factors of Deficiency Diseases; Pernicious Anemia, etc."—Ernest B. Milam.

"Deficiency Diseases as Related to Gynecology, with Hormonal Treatment"—Ferdinand Richards.

Drs. E. C. Swift, L. S. Laffitte, and T. S. Field opened the discussion.

* * *

ORANGE COUNTY MEDICAL SOCIETY

At a meeting of the Orange County Medical Society held recently, the following resolutions were passed with regard to the death of Dr. B. A. Burks:

Whereas, God in His infinite wisdom has taken from our membership our beloved colleague, Dr. B. A. Burks, and

Whereas we, the members of the Orange County Medical Society do hereby feel his loss as a friend, counsellor and a brother practitioner, therefore be it

Resolved, that the Orange County Medical Society express its grief and profound sympathy to his bereaved family, and furthermore, be it

Resolved, that a copy of this resolution be sent to Mrs. Burks, spread upon the copy of our minutes and published in the Florida Medical Journal.

Meredith Mallory, M. D.
L. C. Ingram, M. D.
Fred Mathers, M. D.

March 16, 1938.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Doctor J. T. Bradshaw entertained the Pasco-Hernando-Citrus County Medical Society at Dade City, March 10th. Dinner was served at the Edwinola Hotel, followed by a scientific meeting. Interesting case reports were given by Drs. W. Wardlaw Jones, Wm. Haywood Walters, J. T. Bradshaw, and Claude L. Carter.

Dr. S. C. Harvard invited the Medical Society to meet with him in April.

Those present were: Drs. J. T. Bradshaw, G. R. Creekmore, Claude L. Carter, W. Wardlaw Jones, H. L. Harrell, S. C. Harvard, and Wm. Haywood Walters.

WILLIAM HENRY COX

Doctor William Henry Cox of Brooksville, aged 75, died on March 4, at the Hernando County Hospital.

Doctor Cox was born at Hartford, Alabama, in 1862. He attended the Chattanooga Medical College, from which he graduated in 1888.

Doctor Cox came to Florida in 1900, locating at Live Oak, where he practiced medicine for two years. In 1902, he moved to Brooksville where he practiced until 1917, when he was appointed State Health Officer. In 1929 he was appointed State Prison Physician and served until 1933. He was an honorary member of the Pasco-Hernando-Citrus County Medical Society and rarely missed a meeting. He always took part in the discussion of scientific programs. He believed in the personal administration of the physician, and it was to this noble mission he devoted his life. He was most active until the time of his death. He is survived by his widow, four daughters, and seven sons.

The following resolutions were adopted by the Pasco-Hernando-Citrus County Medical Society, with reference to the passing of Doctor Cox:

"Whereas, God in His infinite wisdom hath seen fit to remove from our midst one of our most beloved brothers, Dr. W. H. Cox, and,

"Whereas, we, the members of the Pasco-Hernando-Citrus County Medical Society, feel deeply the loss of our beloved brother and friend; therefore be it

"Resolved, that the Pasco-Hernando-Citrus County Medical Society expresses its sorrow in the passing of Dr. William Henry Cox; that a copy of this resolution be sent to his family; that a copy be entered on the minutes of this society; that the same be published in the Journal of the Florida Medical Association."

PINELLAS COUNTY MEDICAL SOCIETY

Three meetings of the Pinellas County Medical Society were held during the month of March—on the 4th, 18th and 30th. During these meetings, the following papers were presented, respectively:

"Blood Pressure"—A. R. Frederick.

"Toxicology in Medical Practice"—M. L. Moran.

"Early Diagnosis of an Acute Abdomen"—T. R. Griffin.

Drs. Palmer, Prather, Roush, Simcox and Wood presented "Gleanings from Current Literature" during the first of these meetings.

* * *

ST. JOHNS COUNTY MEDICAL SOCIETY

THE ST. JOHNS COUNTY MEDICAL SOCIETY HAS REPORTED 100% OF ITS DUES FOR 1938. THIS IS ONE OF THE SOCIETIES WHICH SELDOM FAILS TO HAVE A PERFECT RECORD OF DUES PAID. JOHN J. SPENCER IS PRESIDENT; G. WALTER POTTER, VICE-PRESIDENT; VERNON A. LOCKWOOD, SECRETARY; AND A. C. WALKUP, TREASURER. CONGRATULATIONS!

* * *

ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY

THE ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY HAS PAID ITS FULL ASSESSMENT FOR 1938. THIS SOCIETY HAS A MEMBERSHIP OF FOURTEEN ACTIVE AND ONE HONORARY MEMBERS. IT IS HEADED BY R. C. BOOTHE, PRESIDENT; J. D. PARKER, VICE-PRESIDENT; AND A. M. SAMPLE, SECRETARY-TREASURER.

SARASOTA COUNTY MEDICAL SOCIETY

At a recent meeting of the Sarasota County Medical Society, the following officers were elected to serve for the current year:

President—O. H. Cribbins.

Vice-President—A. L. Mathews.

Sec'y-Treas.—J. E. Harris.

* * *

SUMTER COUNTY MEDICAL SOCIETY

THE SUMTER COUNTY MEDICAL SOCIETY IS, AS USUAL, AMONG THE FIRST TO GAIN THE HONOR ROLL OF 100% PAID SOCIETIES. SERVING AS OFFICERS OF THE SOCIETY THIS YEAR ARE: C. L. CARTER, PRESIDENT AND W. E. MITCHELL, SECRETARY-TREASURER. DOCTOR MITCHELL WILL ALSO SERVE AS DELEGATE AT THE COMING CONVENTION.

* * *

TAYLOR COUNTY MEDICAL SOCIETY

At the annual meeting of the Taylor County Medical Society, the following officers were elected for the current year:

President—Ralph J. Greene, Perry.

Vice-President—J. L. Weeks, Perry.

Sec'y.-Treas.—W. J. Baker, Foley.

Delegate to State Convention—R. J. Greene.

Alternate Delegate—J. L. Weeks.

* * *

WASHINGTON-HOLMES COUNTY MEDICAL SOCIETY

EIGHT DOCTORS FROM SIX CITIES COMPRISE THE WASHINGTON-HOLMES COUNTY MEDICAL SOCIETY. THE FACT THAT THESE WIDELY SCATTERED PHYSICIANS HAVE AFFILIATED THEMSELVES SPEAKS WELL FOR ORGANIZED MEDICINE; THE FACT THAT THEIR DUES ARE 100% PAID SO EARLY IN THE YEAR SPEAKS WELL FOR THE SOCIETY AND ITS OFFICERS, WHO ARE: B. W. DALTON, PRESIDENT AND R. H. SEGREST, SECRETARY-TREASURER. DR. G. W. CARTER WILL SERVE AS DELEGATE FROM THIS SOCIETY AT THE NEXT STATE CONVENTION.

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Surgery—General Courses One, Two, Three and Six Months: Two Weeks Intensive Course in Surgical technique with practice on living tissue; Clinical Courses; Special Courses. Courses start every Monday.

Gynecology—Personal Courses starting May 2, June 13 and August 22. Other Courses available every week.

Obstetrics—Two weeks intensive course starting June 6; Informal Course starting every week.

Fractures and Traumatic Surgery—Informal Practical Course; Intensive Ten Day Course.

Urology—General Course One Month; Intensive Course Two Weeks; Special Courses. Courses start every two weeks.

Cystoscopy—Ten Day Practical Course rotary every two weeks.

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ABSTRACT DEPARTMENT

Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.

Congenital Pyloric Stenosis in Sisters: Report of Two Cases—JELKS, EDWARD, Jacksonville, *South. M. J.* **30**:1027-1028 (Oct.) 1937.

Congenital hypertrophic pyloric stenosis, while a relatively common entity, is rarely found occurring twice in children of the same family.

Jelks reviews the available literature from this particular standpoint and reports from his own practice an instance involving the first and third children of one family, both girls. Both underwent operation and made uneventful recoveries.

Treatment of Hemorrhage in Nonhemophilic Patients with an Estrogenic Substance—HEINBERG, C. J., Pensacola, *Arch. Otolaryng.* **24**: 758-761 (Dec.), 1936.

The author believes that if estrogen will check hemorrhage in true hemophilia, it should also be of value to those bleeders who are not classified as true hemophiliacs. Four patients whose clotting time was normal, all of whom had postoperative bleeding, are reported. Theelin was given subcutaneously in all cases, and bleeding was checked in each case in from twenty to thirty-five minutes. Arterial or venous bleeding was not present in any case, but slight capillary oozing occurred in each instance. It is interesting to note that two of the patients were at the age of puberty and the menopause respectively when endocrine disturbances are apt to occur. The author concludes that since ovarian extract has been demonstrated to be of value by Birch in the treatment of hemophilia, it is also of value for certain types of nonhemophilic hemorrhages following surgical procedures.*

**Editor's Note—It should be remembered that estrogenic substance cannot always be relied upon to check hemorrhage even in true hemophilia and that blood transfusion is still the most reliable therapeutic agent we have.*



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Florida Medical Special

To AMERICAN MEDICAL ASSOCIATION



SAN FRANCISCO, CALIFORNIA

For the convenience of members attending the Annual Convention of the American Medical Association, June 13-17, 1938, at San Francisco, California, the Seaboard Railway, Louisville & Nashville Railroad and the Southern Pacific Lines have been named the OFFICIAL ROUTE FROM FLORIDA and offer the following schedule and fares from Florida points to San Francisco:

Lv. Miami	SAL	8:15 A.M.	June	5	Lv. Jacksonville	SAL	9:35 P.M.	June	5
Lv. W. Palm Beach	"	10:05 A.M.	"	5	Lv. Tallahassee	SAL	2:20 A.M.	"	6
Lv. St. Petersburg	"	11:05 A.M.	"	5	Lv. Pensacola	L&N	11:10 A.M.	"	6
Lv. Tampa	"	1:05 P.M.	"	5	Ar. New Orleans	L&N	7:40 P.M.	"	6
Lv. Sarasota	"	10:05 A.M.	"	5	Lv. New Orleans	SP	11:00 P.M.	"	6
Ar. Jacksonville	"	6:10 P.M.	"	5	Ar. San Antonio	SP	2:45 P.M.	"	7

Spend afternoon

Lv. San Antonio	SP	3:15 A.M.	June	8
Ar. Los Angeles	SP	5:00 P.M.	"	9

Spend 2 nights and 2 days in Los Angeles.

Lv. Los Angeles	SP	9:00 P.M.	June	11
Ar. San Francisco	SP	8:00 A.M.	"	12

The above schedule and route were selected by Dr. Herbert L. Bryans, Chairman of Transportation Committee, Pensacola, Fla., and you will note that he has arranged stop-overs at San Antonio and Los Angeles on the going trip. You will note in letters you have received from Dr. Bryans that he has suggested two routes returning, i. e., via St. Louis or Chicago.

Round Trip Summer Tourist Fares

Miami	$131.40	St. Petersburg	$121.75	Tampa	$120.55	Tallahassee	$103.05
West Palm Beach	128.05	Sarasota	123.15	Jacksonville	114.20	Pensacola	98.90

Proportionate fares from other points. Tickets on sale daily.

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W. J. KENEALY, *General Passenger Agent,* 233 West Forsyth St., Jacksonville, Fla.

The Physiology of Hyperpyrexia Produced by Artificial Means—PHILLIPS, KENNETH, Miami, *Medical Press & Circular*, Vol. **CXCI**, Nos. 5039-40 (Dec. 4 & 11) 1935.

That hyperpyrexia produced by physical means differs profoundly in a physiological sense from that produced by disease is revealed by the author through an exhaustive bibliographical search and by his own observations.

With infection, fever is produced not by heat stimulation of the thermogenic center but by toxins, whereas, with artificially produced temperature, the evidence points to the fact that we are dealing mainly with heat retention.

Natural fever elevates the metabolism 7% for each degree F. (Van Hoff's Law). Many cases with artificially produced temperature have rate increases far in excess of this figure. Protein metabolism so markedly increased in "infectious" fever has no counterpart in that produced by physical means.

The usually present upset acid base equilibrium found in fevers of infection has not been found in artificially produced types.

The author warns against too firm a belief in the results of test tube experiments as applied to actual body processes and is of the opinion that there are many other considerations to be taken into account in proving the bacteriolytic value of artificially produced hyperpyrexia.

A Simple Pliable Finger Splint—BURCH, JOHN E., Miami, *J.A.M.A.* **108**:2036 (June 12), 1937.

An ingenious finger splint is described. It is suitable for use where moist applications are needed as in infections of the fingers or infections with finger fractures. The splint is made of wooden applicators lying next to each other, in varying widths, and incorporated in adhesive plaster. The advantages are in the cheapness and availability of the materials, the lightness and elasticity of the splint, the fact that it can be made or cut into any desired widths or lengths, that it is light and needs no padding, and that it can be snugly fitted and held in place with gauze bandages.

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WOMAN'S AUXILIARY NEWS

HEALTH INSTITUTE

Orange County Medical Auxiliary held its Health Institute on the afternoon of March 4, at Sorosis House. Mrs. W. H. Spiers, program chairman, presented three prominent speakers, the first of whom was Dr. Gerry R. Holden of Jacksonville. He illustrated his talk on "Cancer" with lantern slides from the American Society for the Control of Cancer. Dr. Louis Orr of Orlando spoke on venereal diseases, being a member of the State committee for their prevention and control. Doctor Orr recommended among other things blood tests and examinations for venereal diseases before applications for marriage licenses or work as housekeepers, cooks or hospital employees. Dr. R. D. Thompson of the Florida Tuberculosis Sanatorium used x-ray photographs to point out the signs and treatments of various types of tuberculosis.

All three physicians emphasized the fact that complete cures were most probable in the early stages, and much expense and suffering could be prevented by promptness in seeking a competent doctor's examination.

* * *

DUVAL COUNTY

The March meeting of the Duval County Auxiliary was held in the home of Mrs. Edward Jelks with Mrs. Kenneth A. Morris acting as assistant hostess. Mrs. J. H. Owens conducted the business session at which Mrs. J. W. Hayes and Mrs. Edward Jelks were chosen as delegates for the convention to be held in Miami, June 9-11. Mrs. F. W. Krueger, program chairman, introduced Mr. Harold S. Cohn as guest speaker whose talk

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* * *

EXHIBITS

This is an excerpt from the letter written to County Auxiliary Presidents by Mrs. E. W. Veal of Jacksonville:

Just a few short weeks until we meet at our annual convention in Miami. Our State President, Mrs. S. M. Copeland, has asked me to be chairman of the Exhibits Committee this year and with your help we are hoping to stimulate more interest in this branch of our Auxiliary work.

In regard to your exhibit or exhibits. If you have a Scrap Book please bring it or send it by your delegate. If your Auxiliary has not started a Scrap Book yet, maybe you have some clippings from the newspaper of some outstanding work you have accomplished in your community this year. Such clippings arranged on cardboard in some unusual manner make very effective exhibits. Anything connected with pioneer medicine such as old instruments or papers properly labeled will be good. If any organizations in your district such as Nurses Associations, Civic Clubs, etc., have at any time shown posters or health subjects in any form, borrow these to show and we will promise to be responsible for their return in good condition.

REPORTS

Dear County Presidents and Committee Chairmen:

We are rapidly approaching the time of our State Convention to be held in Miami, May 9-11, and should be thinking about the record of our work that is to be turned in at that time. If for any reason you cannot attend the convention and are not represented by a delegate, please send your report to the recording secretary, Mrs. Gordon H. Ira, 1334 Challen Ave., Jacksonville, not later than April 25. If you have any suggestions or recommendations relative to our work for next year, please send them in, typewritten, in time for the Board meeting preceding the annual session.

We are looking to each county group to get its membership and its dues up to date by the end of the fiscal year. Paid up memberships will play an important part in our state meeting.

May I take this opportunity to thank each and every one of you for the fine, splendid work you have done this year and to say that I deeply appreciate your loyal cooperation and support. I have thoroughly enjoyed the work and think we have had a most successful year.

Faithfully yours,

(Mrs. S. M.) MINNIE R. COPELAND,
President Florida State Medical Auxiliary.

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THE SIXTY-FIFTH ANNUAL MEETING OF THE
FLORIDA MEDICAL ASSOCIATION
will be held at
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COMPONENT SOCIETIES BY DISTRICTS—FLORIDA MEDICAL ASSOCIATION

Districts	County Society	President	Secretary	Meeting Date	Councilor and Counties Not Included in First Column	Members Total	Members Paid
Northwest District (A) Panama City July 14, 1938	Bay	W. J. Blackshear, M.D., Panama City	William C. Roberts, M. D., Panama City		A-1-'38 John S. Turberville, M. D., Century	11	8
	Escambia	J. M. Hoffman, M. D., 1221 E. DeSoto St., Pensacola	J. N. McLane, M. D., 204 W. Brainard St., Pensacola	2nd Tuesday 8:00 P. M.		42	12
	Walton-Okaloosa	A. G. Williams, M. D., Lakewood	R. B. Spires, M. D., DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington Holmes	B. W. Dalton, M. D., Vernon	R. H. Segrest, M. D., Bonifay		*Santa Rosa*	7	0
	Jackson	D. A. McKinnon, M. D., Marianna	R. N. Joyner, M. D., Marianna	2nd Tuesday 7:30 P. M.	A-2-'39 N. A. Baltzell, M. D., Marianna	14	11
	Leon-Gadsden-Liberty-Wakulla-Jefferson	W. D. Rogers, M. D., Chattahoochee	B. A. Wilkinson., M. D., Telephone Bldg., Tallahassee	Quarterly 3:00 P. M.	*Calhoun-Franklin-Gulf*	37	16
North Central District (B) Gainesville, October 27, 1938	Columbia	William S. Nichols, M. D., Lake City	Harry S. Howell, M. D., Blanch Hotel Annex, Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M. D., Lake City	16	13
	Madison	E. Long, M. D., Madison	Geo. O. Davis, M. D., Madison			4	
	Taylor	G. H. Warren, M. D., Perry	J. C. Ellis, M. D., Perry	Last Friday 8:00 P. M.	*Baker-Dixie-Hamilton-Lafayette-Suwannee*	8	6
	Alachua	T. A. Snow, M. D., 103 E. University Ave., Gainesville	H. M. Merchant, M. D., 124 E. University Ave., Gainesville	2nd Friday 7:30 P. M.	B-4-'38 A. B. Albritton, M. D., Wildwood	25	7
	Marion	Carney W. Mimms, M. D., Commercial Bank Bldg. Ocala	R. C. Cumming, M. D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P. M.		23	18
	Pasco-Hernando-Citrus	W. Wardlaw Jones, M. D., Dade City	G. R. Creekmore, M. D., Brooksville	2nd Thursday 7:00 P. M.		14	11
	Sumter	Clyde L. Carter, M.D., Wildwood	W. E. Mitchell, M. D., Bushnell	2nd Tuesday	*Bradford-Gilchrist-Levy-Union*	5	4
N. E. District (C) Ponte Vedra Sept. 15, 1938	Duval	J. Lunsford Boone, M. D., 500 Profesaional Bldg., Jacksonville	George W. Croft, M. D., 713 Greenleaf Bldg., Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M. D., Jacksonville	158	98
	St. Johns	John J. Spencer, M.D., 32 Saragosaa St., St. Augustine	Vernon A. Lockwood East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	*Clay-Nassau*	10	
	Putnam	Z. Brantley, M.D., Grandin	Allen P. Gurganious, M.D., Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'38 Hugh West, M. D., DeLand	10	6
	Volusia	Hugh West, M. D., DeLand	R. L. Miller, M. D., 258½ S. Beach St., Daytona Beach	2nd Tuesday 7:30 P. M.	*Flagler*	40	19
Southwest District (D) Bradenton, September 29, 1938	Hillsborough	Joseph W. Taylor, M. D., 706 Franklin St. Tampa	James S. Grable, M. D., 811 Citizens Bank Bldg., Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M. D., Plant City	99	1
	Manatee	John F. Mason, M. D., Bradenton	M. M. Harrison, M. D., Bradenton	3rd Tuesday 7:00 P. M.		14	12
	Pinellas	J. A. Strickland, M. D., 712 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D., 1005 Equitable Bldg., St. Petersburg	1st and 3rd Fridays 6:30 P. M.		90	70
	Sarasota	O. H. Cribbins, M. D., 224 Commercial Court, Sarasota	J. E. Harris, M. D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P. M.		15	12
	DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring	Howard V. Weems, M.D., Sebring	2nd Tuesday 8:00 P. M.	D-8-'38 J. A. Simmons, M. D., Arcadia	19	
	Lee	H. Quillian Jones, M. D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M. D., 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P. M.		13	11
	Polk	W. W. Shafer, M. D., Haines City	J. R. Boulware, Jr., M. D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	*Charlotte-Collier-Glades-Hendry*	61	39
South Central District (E) Leesburg, Nov. 10, 1938	Brevard	G. E. Christle, M.D., Titusville	I. K. Hicks, M.D., Melbourne	3rd Tuesday	E-9-'38 W. C. Page, M D., Cocoa	11	7
	Lake	Harry T. Fenn, M. D., Mount Dora	W. L. Ashton, M. D., Umatilla	1st Thursday 12:30 P. M.		17	15
	Orange	H. A. Day, M.D., 209 Exchange Bldg., Orlando	Hewitt Johnston, M. D., Box 2002 Orlando	3rd Wednesday 8:30 P. M.		71	54
	Seminole	J. N. Tolar, M. D., Sanford	Douglas G. Scott, M. D., Box 489 Sanford	2nd Monday 7:00 P. M.	*Osceola*	13	100%
	St. Lucie-Okeechobee-Indian River-Martin	R. C. Boothe, M.D., Ft. Pierce	Adrian M. Sample, M.D., Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M. D., Ft. Pierce	14	13
S. E. District (F) Ft. Lauderdale Oct. 13, 1938	Broward	A. B. Connor, M. D., Sweet Bldg., Ft. Lauderdale	Oliver C. Brown, M. D., 915 Sweet Bldg., Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'38 F. K. Herpel, M D., West Palm Beach	31	23
	Palm Beach	V. M. Johnson, M.D., Good Samaritan Hospital, W. Palm Beach	J. R. Sory, M.D., 616 Harvey Bldg., West Palm Beach	4th Monday 8:00 P. M.		55	28
	Dade	Arthur H. Weiland, M. D., 227 Aragon Ave., Coral Gables	Claude G. Mentzer, M. D., 808 Huntington Bldg., Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M. D., Miami Beach	275	114
	Monroe	Harry C. Gaiey, M. D., 532 Fleming St., Key West	W. R. Warren, M. D., 511 Eaton St., Key West	1st Sunday 9:00 P. M.		3	

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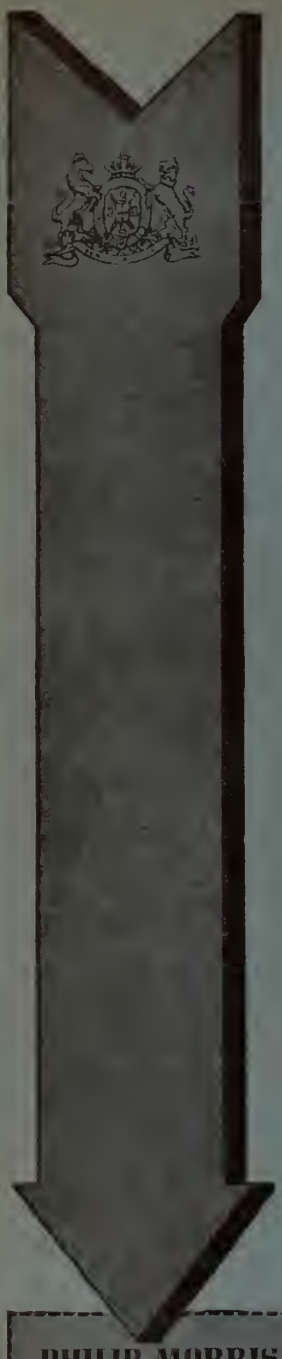
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American Medical Association, San Francisco, June 13-17, 1938.
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Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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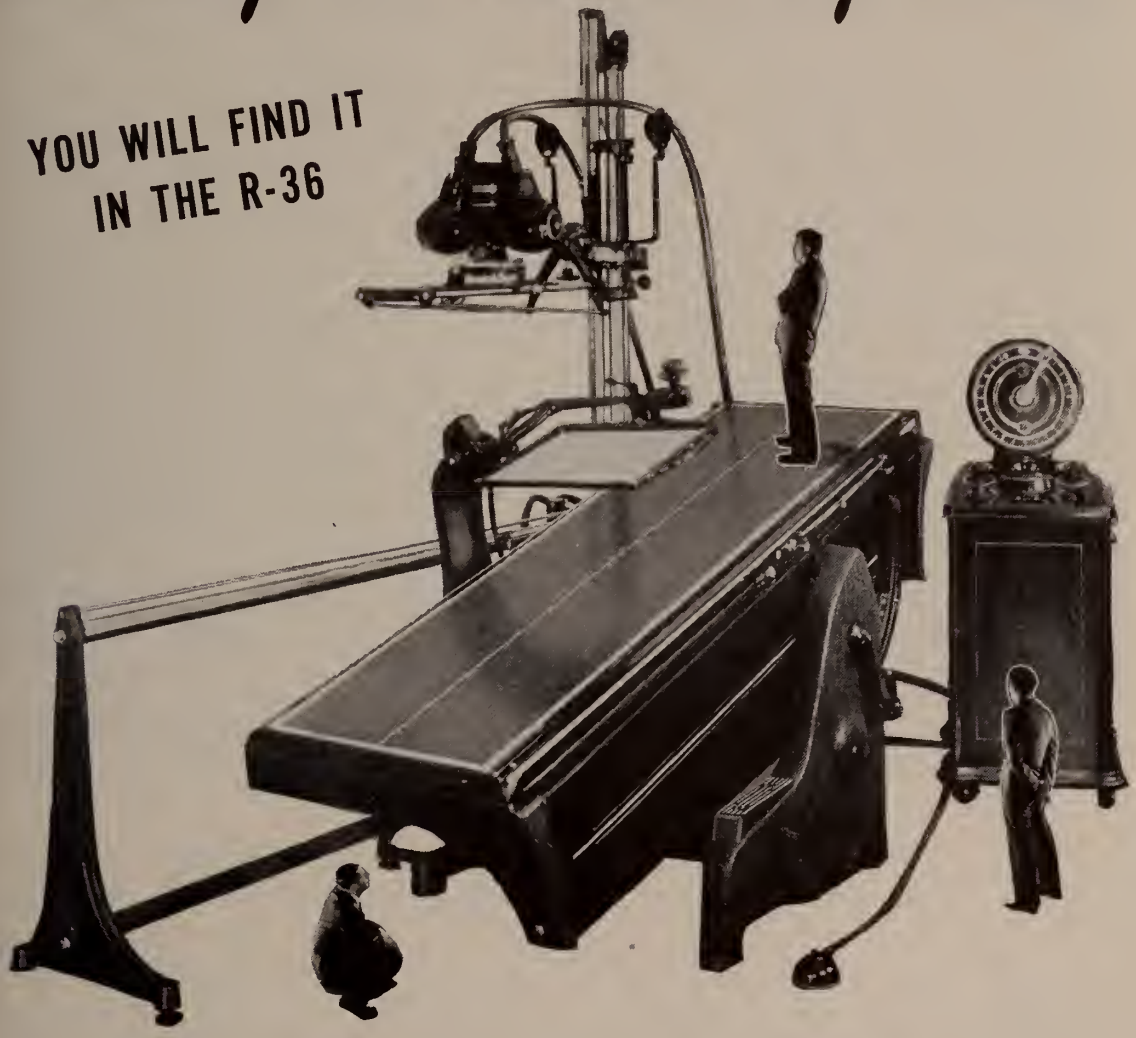
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III. EXHAUSTING OR PREHEATING

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In commercial canning practice, certain operations—specifically the blanch—may aid in elimination of gases from raw food tissues. However, main dependence is placed upon what are known as "exhausting" or "preheating" operations, not only to expel gases from raw foods, but also to exclude air from the can.

Briefly, the exhausting operation is accomplished by mechanically passing the open can containing the raw food through a so-called "exhaust box" in which hot water or steam is used to expand the food by heat and drive out air and other gases contained in the food and in the can. The times and temperatures used in commercial exhausting operations will naturally vary with the nature of the product (1).

After exhausting, the can is immediately permanently sealed, heat processed and cooled. During cooling, the contraction of the heated contents of the can creates the vacuum normally present in commercially canned foods.

With certain products, instead of exhausting as described above, the same effect is produced by preheating the food in kettles or similar devices; filling into the cans while still hot; and immediately sealing the containers. With still other products, an exhausting effect is produced by adding boiling water, syrup or brines to the food in the can. In some instances, exhausting is accomplished by mechanical rather than by thermal means. Specially designed sealing or "closing" machines are used to withdraw air and other gases by applying high vacuum to the can and immediately sealing on the cover.

Such in brief are the purposes of commercial exhausting operations and the means by which they are usually accomplished. Modern canners recognize that these operations are most important to the success of their canning procedures. They appreciate that only by strict supervision and control of exhausting operations can the quality and nutritive values of their products be maintained at a consistently high level.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

(1) Appertizing or The Art of Canning", A. W. Bitting, The Trade Pressroom, San Francisco, 1937.

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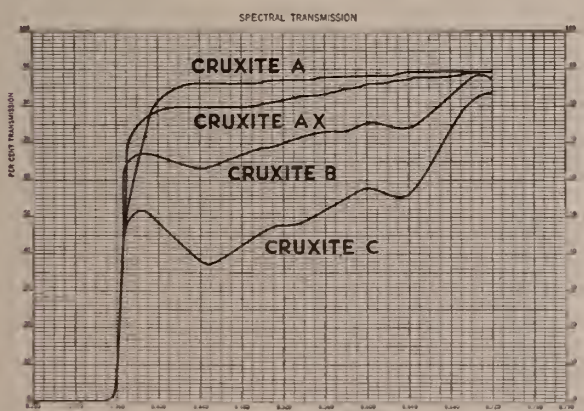
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXIV | Jacksonville, Florida, May, 1938 | Number 11

PREOPERATIVE AND POSTOPERATIVE CARE IN THE SURGICAL TREATMENT OF PULMONARY TUBERCULOSIS*

KENNETH A. MORRIS, M. D.,
Jacksonville.

No discussion of the preoperative and postoperative care in the surgical treatment of pulmonary tuberculosis would be complete without a few remarks concerning the selection of the patient for operation. It is not enough for the surgeon to know the operative technique. He should know tuberculosis and, in a sense, be his own diagnostician. However, he will still make many mistakes unless each patient is carefully selected by a chest team composed of internist, surgeon and roentgenologist. This conference should not merely consist of a study of x-ray films. The patient must always be seen and his clinical condition carefully considered. It is rather embarrassing to select a patient for thoracoplasty on the basis of a study of the x-ray films, and then to find him either in a moribund condition or dead.

It is not the purpose of this article to discuss in detail the indications and contraindications for surgery but, generally speaking, patients should show some ability to help themselves either by rest or by simple methods of collapse therapy. We should keep in mind the fact that pulmonary tuberculosis is a local manifestation of a constitutional disease, and the patient should be considered as a whole. He may have a considerable amount of disease in other organs in his body. Practically the same precautions should be taken as in preparing a patient for any major surgical procedure. A careful history and physical examination is, of course, important. The hemoglobin and red cell count should be determined to see if transfusions are necessary. It is also well to have the patient out of bed for a few days before operation. This will help prepare the heart and other organs of the body for the added strain of an operation.

When we consider the lung itself, the question of sufficient air space or vital capacity is important. When the diseased lung has been previously collapsed, we know the vital capacity is sufficient. If pneumothorax is still present, the air should be aspirated either before or at the time of the operation. When thoracoplasty is attempted in bilateral cases, Lahey and Overholt believe that one lobe should be functioning on each side or the vital capacity should not be below 1100 cc. Postural drainage is important before operation if large cavities are present, especially when there is a fluid level in the cavity. We have found that it is better to operate in the afternoon because the patient usually clears the lungs by expectoration in the morning.

Many types of anesthesia have been advocated for thoracoplasty. Ether is, of course, contraindicated. Nitrous oxide and ethylene have been used satisfactorily in combination with the barbiturates. More recently cyclopropane has been considered ideal because of the high amount of oxygen that can be used when it is administered. We have found the combination of avertin using less than a basal dose, 40 to 60 mg. per kilo of body weight combined with nitrous oxide, ethylene, or local novocaine, to be very satisfactory. Only a small amount of gas anesthesia is necessary when avertin is used, and the small amount of avertin used is not enough to abolish the cough reflex. The patient reacts quickly and does not have the ashen color of those who receive larger doses. A hypodermic of morphine gr. 1/6 and atropine gr. 1/150 is all the preoperative medication that is necessary.

There is really very little to say about the postoperative treatment. Very little treatment is required if the patients are carefully selected, properly prepared and operated upon conservatively with a fair amount of skill. With the aid of small doses of morphine they seem to take care of themselves. We used to treat the postoperative shock when the patient had returned to his room, but now we give saline and glucose-acacia solution intravenously continuously during the operation, and postoperative shock is rare. Conservative multiple stage operations, gentleness and a technique in which very little blood

*Read before the Annual Meeting of the Florida Tuberculosis Association, Miami, May, 1937.

is lost does much to prevent shock. Hemorrhage should be a very rare complication. Saline hyperdermoclysis and glucose intravenously to replace lost fluids may be given advantageously the first twelve or twenty-four hours. After that or sooner patients take liquids and food well.

The patient is placed upon the collapsed side when he is returned to his bed. This position is maintained unless he finds it too uncomfortable and then he is allowed to choose his own position. The proper position steadies the mediastinum and prevents paradoxical movement of the chest wall. Dyspnea and cyanosis occasionally occur and may be due to a too tight dressing. If dyspnea is not relieved by simple measure, the patient should be placed in an oxygen tent and kept there until he is out of danger. It might even be wise to place the patient in an oxygen tent immediately following operation whether cyanosis and dyspnea are present or not. It has been shown recently that considerable anoxemia occurs following any operation. This would of course be more marked in patients with pulmonary tuberculosis. We believe with Graham that pulmonary edema is in reality a tuberculosis pneumonia due to an extension of the diseased process and caused by too radical an operation. Pleural effusions or pneumothorax may occur and aspiration of the chest may be necessary. With careful technique, wound infection should not occur often.

We try to have the patient out of bed by the fourth or fifth day and exercise of the arms is started as soon as possible to prevent deformity of the spine. As to the interval between operations, we agree with Overholt that rapid successive stages are not always necessary, and that time can often be given the patient to obtain full benefit from each procedure. This is especially true if the first-stage operation has been thorough, or where lung mobilization is done.

The question as to whether cavities have been completely closed by thoracoplasty can best be determined by bronchography or by the injection of lipiodol according to the method of Cabbitt, Singer and Graham. Ordinary x-ray films will not always show these cavities. We have not always been able to completely close some large cavities. Negative sputum, decrease in the amount of sputum, freedom from temperature and clinical improvement are fair guides as to the progress of the patient, but are not always reliable. Our chest team considers the sedimentation test to be of considerable value. Other conditions may, of course, cause a drop in the sedimentation rate, but when there is a drop we feel that it is up to us to prove that it is not due to active tuberculosis. Finally, we should remember that the patient still has tuberculosis, and that surgical treatment is only an aid. Medical care of the patient should always be continued by the patient's physician.

238 W. Church St.

BONE INJURIES IN GENERAL PRACTICE*

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Bone injuries are becoming more and more common and the majority of these are being treated at present, and will be in the future, by the general practitioner. There is no reason why a man doing general work should not be able to treat successfully the bulk of the common bone injuries. However, in order to do this he must be well versed in certain fundamental considerations.

Every fracture or dislocation must be considered an emergency. The fracture of the os calcis is an exception, and usually is not reduced until a week to ten days posttrauma. Even here several of the best fracture men are reducing them earlier. The best way to prevent and reduce swelling is to accurately and as gently as possible replace the fractured bones into as good an anatomical reposition as possible. Never let a fracture or dislocation be unreduced for long unless the patient is in such shock that any interference is contraindicated. Torn muscles, fasciae, tendons, ligaments, and at times nerves and blood vessels are often interposed between or partially pierced by the sharp points of the fragments. Traction, firm and steady, is usually a first-line defense in avoiding further trauma to these soft tissues. Also, traction alone in the anatomical axis of the injured part will reduce most of the displacement. In this connection,

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always be sure to avoid injury to an uninvolved joint from too strong or forceable traction or manipulation. For instance, in exerting pull on the upper extremity for bony injuries about the elbow, have the assistant exert counterpull about the surgical neck region of the humerus and not on the axilla or chest.

Let us not forget that the "golden six-hour period" applies equally well to lacerated tendons, torn muscles, and other products of trauma. If seen for the first time longer than six hours posttrauma, delayed suture is the best thing to do even if thorough careful debridement is instituted. By delayed suture is meant—placing the sutures and leaving the wound open or loosely closed until ten to twelve hours later. At this time if there are no signs of any infection the sutures may be tied. It is always a good plan to leave adequate drains for two or three days in any potentially infected field.

The matter of anesthesia is an important one and the choice of anesthetic depends a great deal upon where these traumatic cases are treated. Office practice, in many cases, must necessarily be a different undertaking from hospital practice. In the office or clinic novocaine has probably proved itself the best anesthetic for a great majority of bone cases. Novocaine as a local anesthetic, however, must be carefully given and certain factors taken into consideration before it is used. I have injected novocaine into fractures of both bones of the forearm in a young boy of five years, but I was pretty certain that this particular tough young protege of the sidewalks of New York would take it. Usually, however, novocaine should not be administered to children or to nervous or upset adults. Surgical asepsis must be adhered to, and the needle must be in the hematoma before the novocaine is injected. I never use epinephrin because of the danger of its admission into the blood stream. The circulation can take care of a large amount of novocaine without exhibiting much shock, but occasionally we meet a patient who reacts violently to it. Hence, it is better to inject the solution rather slowly and watch carefully for any toxic effects.

The intravenous anesthetics, such as evipal soluble and penthothal sodium, are rapidly coming into general usage and for certain cases are excellent. However, even greater care must be taken here than in the use of procaine hydrochloride, and we must all be thoroughly aware of both the contraindications and the exact method of administration of these newer basal anesthetics. In hospitals, where the more serious injuries are handled, I find that avertin with amylene hydrate, as a basal anesthetic is of great value. Combined with the usual preoperative medications and supplemented with gas-oxygen, ethylene or ether, even the prolonged bone procedures can be carried out with the minimum of shock and postoperative complications. I have found that in infants and children, where only a short anesthesia is required, vinethene works admirably. It is easily given, acts about as quickly as ethyl chloride, with less danger, and gives excellent relaxation with a minimum of postanesthetic nausea, vomiting, and restlessness.

The "gadget age" has been engulfing us the last few years and the man who has the most instruments, splints, frames, and other mechanical contrivances has been the envy of all his colleagues. Hospitals have been cluttering up their spare rooms with all of these paraphernalia. Let me reiterate what has been said over and over again, namely, that "it is not the splint but the man behind it." These aluminum affairs should be used only as emergency splints, where we want wet dressings, or where a joint or limb is to be merely protected and not thoroughly immobilized. There is nothing in the same class with molded plaster of Paris splints or a well applied plaster cast. When we put a Colles' fracture in a basswood or an aluminum splint we are courting disaster. The rigid planes of metal or wood can not be made to fit accurately any limb, even with a great amount of padding, which is distinctly undesirable. At the Reconstruction Hospital in New York City, all of our plaster splints were lined with just Canton flannel, and very seldom did we get any pressure symptoms. Böhler of Vienna, applies the plaster right onto the skin, but I like to use stockinette for nonpadded plaster casts, which is following the practice of Forrester of Chicago. When plaster is applied with the minimum of padding, it must be very accurately and carefully molded to the limb, and usually it is better to put a thin layer of

felt or silence cloth over the bony prominences, such as the styloid processes, the malleoli, the tibial or femoral condyles, the patella, and especially over the head of the fibula, below which the superficial peroneal nerve winds its way.

For Colles' fractures, the anterior and posterior molded plaster splints are necessary, for with the simplest of fractures in this region there is a tendency for dorsal overriding, telescoping, and the formation of a new or recurrent silver fork deformity. Where there is any question of such a possibility, the wrist should be put into the Cotton-Loder position of acute flexion and ulnar deviation. In about ten days to two weeks these splints can be replaced by others with the wrist in the midposition. For Pott's fractures and others of the lower leg, the use of the posterior and lateral or "U" splints is usually preferable to the circular plaster cast, even though it is bivalved. Molded plaster splints leave a free space on the dorsum of the limb for inspection and swelling, and the lateral or sugar-tong splints can be removed with the limb being adequately immobilized by the posterior splint for inspection or treatment of cutaneous injuries. The sugar-tong or "U" splints are often very useful when applied around the elbow or the shoulder. Plaster splints are not hard to apply, and still hold a unique place in treatment of bone injuries. If we could treat our patients in hospitals as long as we wanted to, the traction and suspension methods in many instances would be preferable to the plaster of Paris casts or splints. These latter, however, enable the patient to be ambulatory or to be taken home.

Let me warn the men doing general practice against the indiscriminate and occasional use of Kirchner wires and Steinman pins and other skeletal appliances. What I said about the nonpadded plaster cast and splints applies even more to the use of these internal skeletal devices. Both adequate training and experience are needed in order to know the pitfalls in the use of such surgical measures. The vast majority of all fractures of the body can be adequately treated without having to use any nails, wires, screws or plates. It seems so simple and easy to put a few pins in here, a few wires there, pull our fracture down, and immobilize in a plaster cast. Many authors are filling the Journals with these skeletal traction methods, and to read them you would think that we had reached the last word in fracture therapy. However, one osteomyelitis resulting from such use will make us think before we keep on merely putting in nails. Of course, this skeletal immobilization is a contribution to fracture work and has to be used in certain instances. But, such methods should be left to the men doing a large amount of fracture work, and should not be attempted by the general practitioner. This "gadget age" has reached its climax, and in a few years we will be settling back to the same sound practices of fracture treatment that we were doing a few years ago, using the newer methods in a sane and well-informed manner.

Conclusion: Treat the injured patient for his shock as well as for his injuries; treat him soon, and reduce as soon as possible all bony displacements with the least possible added trauma to the parts affected; remember the "golden six-hour period"; acquire the habit of using plaster of Paris, in place of the lazy man's aluminum ware; keep your feet on the ground, and do not become agog about the gadgets.

11 Lucerne Circle.

THE USE OF CHAULMOOGRA OIL IN THE TREATMENT OF CHRONIC ARTHRITIS

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(The Chaulmoogra Oil Used was Supplied Through the Kindness of the Research Laboratories of the Eli Lilly Company).

The treatment of nonspecific arthritis remains a major problem. In spite of extensive investigation during the past years, the etiology of this condition is still obscure. Until it is determined, treatment must continue to be largely empirical and therefore unsatisfactory in many respects. The innumerable measures which have been advocated as beneficial vary widely in their pharmacological and physiological actions. Some have been found to be definitely helpful while others are only rarely of value. Many authorities feel that present means of treatment are directed against symptomatic manifestations rather than the disease process itself and that therefore no single therapeutic plan now available can prove very satisfactory.

We were familiar with the observations and

reports of McIlhenny[1] who, noting the absence of arthritis among lepers, treated a number of cases of arthritis with chaulmoogra oil and reported excellent results in various types of cases. Similar results were later reported by Hebert.[2] It was also noted in these two papers that there was a little difference in the results obtained in cases of atrophic and hypertrophic arthritis. With this work in mind, we undertook to make a further clinical study of the results of chaulmoogra oil therapy in a series of patients with nonspecific arthritis of various types.

Chaulmoogra oil[3] has a definite beneficial action, particularly against the acid-fast organism.[4] Some attribute its beneficial effect in leprosy to the nonspecific action of its content of the unsaturated chaulmoogric and hydnocarpic acids;[5] others to the influence of the oil on the metabolism of the bacteria[6]: or to the production of a local or general reaction. This latter has been disproved by Lara and Lagrosa.[7]

A number of esters and various preparations of chaulmoogra oil have been employed in the treatment of leprosy, including the ethyl stearate, ethyl oleate, olive oil esters and the whole oil with 0.5 per cent iodine. In the Botsabelo Leper Asylum the ethyl ester with sodium morrhuate was used until 1925.[8] Chaulmoogra oil with creosote (hydnocreosol) was used from 1925 to 1927 and since then sodium hydnocarpate (alepol) has been employed and found more easily tolerated. At the Carville Leprosarium in Louisiana, the formula of Johansen[9] has been found most satisfactory. It consists of 90 per cent chaulmoogra oil, 10 per cent olive oil to decrease the viscosity and 0.2 per cent benzocaine as a local anesthetic. It is this formula that we have used in the treatment of arthritis.

We are very conscious of the empirical nature of this form of treatment and of the fact that the course of chronic arthritis is frequently marked by spontaneous remissions. Any attempt at evaluation of this type of therapy must therefore await its application in large numbers of suitably controlled cases. Our own experience would seem to indicate that chaulmoogra oil does give definite relief in chronic arthritis and is therefore worthy of further trial in the treatment of that disease.

Classification of Cases

We have used the classification of the American Association for the Study and Control of Rheumatic Diseases, namely; atrophic, hypertrophic and mixed types. In our own series the mixed type predominated. Perhaps we extended the boundaries of this group too far, but we endeavored to select only clear cut atrophic and hypertrophic cases for these respective groups. Accurate classification of an individual patient was, however, frequently difficult. Some patients had atrophic arthritis in some joints and x-ray evidence of hypertrophic changes in others. There were encountered other patients in whom hypertrophic bony changes were accompanied by the soft tissue features of the atrophic form. Cases of these types were placed in the mixed group. This difficulty in accurate classification has been stressed by Pemberton who quotes a report of the British Ministry of Health in which 13 per cent of all cases studied could not be considered either atrophic or hypertrophic.

As a matter of interest, we recorded our diagnosis in a number of unacceptable patients who presented themselves for treatment. They included patients with syphilitic periostitis; peripheral, toxic and diabetic neuritis; postural defects; intercostal neuralgia; "sciatica"; gonorrheal arthritis; rheumatic fever, menopausal and other gynecological symptoms; peripheral vascular disease; varicose veins; and bone tumors. We were impressed with the necessity for adequate study and accurate diagnosis in each case if any form of treatment is to be appraised.

Treatment

Our studies were made in the medical clinic of the Graduate Hospital of the University of Pennsylvania. The cases treated were referred to the various clinical departments for the investigation of possible etiologic factors such as foci of infection with toxic absorption, endocrinopathies, postural defects, etc. Laboratory studies were limited to urinalyses, blood counts and serology except where others were indicated. X-ray examinations were made in all cases and, in a few, were repeated following treatment.

Treatment was limited to the use of chaulmoogra oil. All other therapy was discontinued. Foci of infection were not removed and no diet was prescribed. Treatment by chaulmoogra oil was postponed in cases recently treated by other methods in order that our results might be more definitely evaluated.

In a small number of cases chaulmoogra oil was administered orally, either alone or in combination with the intramuscular treatment.

Several types of enteric coated capsules were employed, and also tablets of the sodium salt of the fatty acids of the oil. Thus far our results with oral treatment have been inconclusive. This paper deals, therefore, with the results of the intramuscular treatment in which we have used only the formula previously mentioned, consisting of 90 per cent chaulmoogra oil, 10 per cent olive oil and 0.2 per cent benzocaine. The planned course of treatment which we employed consisted of eight intramuscular injections of chaulmoogra oil (5 cc. each) within six weeks; the first four bi-weekly and the others at weekly intervals.

Method of Administration

Among the earlier cases in our series we had several rather marked local reactions. In one case there developed a sterile gluteal abscess requiring aspiration and in others there developed painful indurated areas lasting several days. These reactions were attributed to the slow absorption of the rather irritating oil in the facial planes and fatty tissues, where it is frequently distributed when the common method of injection in the buttock is employed. This is in the upper outer quadrant of a circle 2 to 2½ inches in diameter with its center at the intersection of a vertical and horizontal line each bisecting the buttock. When a needle is inserted in this area it is difficult to determine whether its point lies in the superficial fatty tissues, the gluteus maximus or the underlying intramuscular fascia. If one plunges too deeply the superior and inferior gluteal arteries, the sciatic nerve or the joint capsule may be encountered.

We have avoided these dangers by choosing a site in the upper and lateral margin of the buttock, about 1½ to 2 inches below the crest of the ileum and above the border of the gluteus maximus. In this area a 3 or 4 inch needle is plunged into the single subcutaneous structure, the gluteus medius. The needle is allowed to touch the ileum and is then withdrawn no more than one-fourth inch prior to injection to avoid the subcutaneous tissues. The oil is then injected in the usual manner after first pulling on the plunger to test for the presence of a blood vessel.

Cases

The following seven cases selected from our series of 65 are considered representative of the various types of arthritis treated.

Case 1. R. S., white female, aged 30, was admitted to the hospital on October 19, 1933.

Diagnosis: Atrophic arthritis, involving the proximal interphalangeal joints of both hands, the wrists, elbows and left knee.

Course and Condition on Admission: The onset of illness was 5 years previous when 5 months pregnant, with marked exacerbation during second pregnancy 3 years later. For the past 18 months she had been totally disabled. She was unable to comb her hair or to walk without assistance. All joints involved were painful, enlarged, hot and tender with some limitation of motion. She had lumbrical atrophy and typical spoon-shaped wrists. She was nervous and depressed, pale and undernourished, and had poor oral hygiene, dental caries and gingivitis, obstinate constipation and slight talipes valgus of the left foot.

Laboratory Studies: Urinalysis-trace of albumin. Blood Count: erythrocytes 3,790,000; hemoglobin 46%, 7.5 gms.; leukocytes 6,400; neutrophils 74%; lymphocytes 23%; monocytes 3%. Wassermann — negative. Blood chemistry — normal.

X-ray Examination: Marked atrophic arthritis of hands and knees.

Previous Therapy: Termination of pregnancy 2 years previously, dental extractions, tonsillectomy, dietary regimen (poorly followed), salicylates, physiotherapy and hydrotherapy, with no relief.

Treatment: Chaulmoogra oil 5 cc. intramuscularly for 5 injections within one month. Gluteal abscess following fifth injection was aspirated and found sterile. Some local soreness followed other injections.

Results: Marked improvement after third injection; entire absence of pain after fourth injection. One week after fifth injection, joints had shown rather marked objective improvement. She was seen at monthly intervals and joints returned to normal function but the involved finger joints remained enlarged. She remained symptom-free and her general health and appearance improved remarkably. She again became pregnant and delivered a healthy baby in October, 1934. Six weeks later she developed a recurrence which rapidly became worse until she presented the same clinical picture as previously described. Treatment was repeated and after two injections of 5 cc. each of chaulmoogra oil at weekly intervals she again became symptom free and was well when last seen, seven months later.

Case 2. C. H., white female, aged 55, was first seen on October 19, 1933.

Diagnosis: Atrophic arthritis involving the

proximal interphalangeal joints of both hands, the wrists, elbows, shoulders and knees.

Course and Condition on Admission: Since onset 6 years previous there had been progressive increase in severity until, upon admission, the patient was totally disabled, requiring assistance to dress and walk. All involved joints were painful, swollen and tender with marked limitation of motion. She had typical fusiform fingers, lumbrical atrophy and spoon shaped wrists.

Laboratory Studies: Urinalysis—negative. Blood count—erythrocytes 4,500,000; hemoglobin 55%, 9.5 gms.; leukocytes 8,000; neutrophils 55%; lymphocytes 37%; monocytes 6%; basophils 2%. Sedimentation Index—20 mm. Wassermann — negative. Blood Chemistry — normal.

X-ray Examination: Marked atrophic arthritis of hands and knees.

Previous Therapy: Tonsillectomy and dental extraction, salicylates, physiotherapy, vaccines (stock and autogenous), diet (low carbohydrate), colon irrigations and symptomatic treatment. She had been hospitalized for 2 weeks and discharged without improvement.

Treatment: Ten injections of chaulmoogra oil (5 cc. each) intramuscularly twice weekly for 4 injections, weekly for 2 injections and biweekly for 4 injections.

Results: Some soreness in buttock for 2 days after each injection but no induration. After fourth injection she claimed about 50 per cent improvement. She was symptom-free after the eighth injection but there remained some limitation in joint movement, particularly of the hands. This was not benefited by the two subsequent injections. She has reamined symptom free and mobility has increased.

Case 36. R. B., white female, aged 34, was seen on July 21, 1934.

Diagnosis: Mixed arthritis involving both knees and interphalangeal joints of both hands.

Course and Condition on Admission: For the past five years she had had pain and tenderness in the right knee and required assistance in walking. The left knee and hands had become involved 4 months previously with marked tenderness, swelling, crepitus and limitation of movement, requiring the use of a cane and crutch. She also had marked varicosities in both lower extremities and was under treatment for syphilis for a year.

Laboratory Studies: Urinalysis—faint trace of albumin. Blood Count — erythrocytes 4,560,000; hemoglobin 61%, 10 gms.; leukocytes 9,300; neutrophils 65%; lymphocytes 22%; monocytes 9%; eosinophils 3%; basophils 1%. Sedimentation Index—100 mm. Blood Chemistry—normal. Wassermann—negative.

X-ray Examination: Hypertrophic changes of both knees.

Previous Therapy: Antisyphilitic, physiotherapy, liniments and symptomatic treatment.

Treatment: She received 8 injections of chaulmoogra oil (5 cc. each) these being given twice weekly for 4 injections and weekly for 4 more. She had a slight local reaction after the fourth injection.

Results: After the third injection the patient was markedly improved, coming to the clinic in a happy mood and without the assistance of her crutch. After the fourth injection she was symptom free. Following the eighth injection swelling and tenderness of her joints had disappeared though the crepitus remained.

Case 27. T. H., white male, aged 62, was first seen on December 10, 1933.

Diagnosis: Mixed type of arthritis involving the lumbar spine, right sacro-iliac joint and the hip joint.

Course and Condition on Admission: Pain in knees when walking and on extremes of joint motion and also tenderness over right sacro-iliac joint of 3 years' duration, which had become progressively worse during the past 2 years. He was diabetic and required 20 units of insulin daily for standardization. He had had typhoid fever and pneumonia in his youth and had been edentulous for 5 years. No foci of infection were found by consultants.

Laboratory Studies: These were all negative except blood sugar which was maintained at 110 to 130 mg. per 100 cc.

X-ray Examination: Moderate atrophic arthritis at the right hip, hypertrophic arthritis of the lumbar spine and the right sacro-iliac joint.

Previous Therapy: Salicylates, physiotherapy and dental extractions.

Treatment (in Hospital Ward): Five injections of chaulmoogra oil (5 cc. each) intramuscularly over a period of one month.

Results: A slight amount of pain in buttock for 2 days following each injection. There were no thermal reactions and leukocyte count on two occasions during treatment showed no rise.

The patient was discharged from the ward after the fifth injection with marked improvement. When seen one month later he was symptom-free. His glucose tolerance improved and insulin was discontinued. Five months later, May 10, 1934, he complained of some recurrence of pain. Oral medication was begun, the patient taking enteric coated tablets of chaulmoogra oil, 3 cc. daily, until again symptom free two months later. He had had no recurrence when last seen.

Case 37. D. E., white female, aged 58, was seen on August 21, 1934.

Diagnosis: Mixed type of arthritis involving the lower lumbar vertebrae, sacro-iliac joints and both knees.

Course and Condition on Admission: Patient complained of backache and pain in both knees and pains radiating along the distribution of the left sciatic nerve of five months' duration. These symptoms had become progressively worse. The knees were tender and swollen and there was crepitus and some limitation of motion. She had had frequent sore throats and the tonsils were grossly infected.

Laboratory Studies: Urinalysis and Blood Chemistry — negative. Blood Count — erythrocytes 4,650,000; hemoglobin 67%, 11 gm.; leukocytes 6,000; neutrophils 40%; lymphocytes 51%; monocytes 5%; eosinophils 3%; basophils 1%.

X-ray Examination: "Osteoarthritis" of lower lumbar vertebrae and sacro-iliac joints with slight hypertrophic processes in knees.

Previous Therapy: Physiotherapy and symptomatic treatment.

Treatment: Eight injections of chaulmoogra oil (5 cc. each) intramuscularly at weekly intervals.

Results: Definite improvement after fourth injection. Following the eight injection, sciatic pain had disappeared, backache and pain in knees had been greatly relieved. One month later the patient was symptom free. Tenderness and swelling had disappeared but crepitus remained.

Case 50. J. G., white male, aged 65.

Diagnosis: Hypertrophic arthritis involving right knee and right shoulder.

Course and Condition on Admission: Onset 25 years previous; worse in humid weather and with increased activity. Some prominence of both knees with marked crepitus in knees and right shoulder. No foci or infected tissue could be found.

Laboratory Studies: Entirely negative.

X-ray Examination: Marked hypertrophic arthritis of both knees with advanced calcification of all blood vessels.

Previous Therapy: The patient had tried all of the common symptomatic remedies, liniments and physiotherapy.

Treatment: Eight injections (5 cc. each) of chaulmoogra oil intramuscularly twice weekly for two weeks, then weekly for one month.

Results: No improvement.

Case 52. H. O., white male, aged 56.

Diagnosis: Hypertrophic arthritis of lower lumbar spine and sacro-iliac joint.

Course and Condition on Admission: Duration 3 years with parietal neuralgia in the area of distribution of the right twelfth thoracic and first and second lumbar nerves. He had slept in a chair for 18 months because of inability to lie down and had lost 20 pounds of weight during the last year. Ileocolonic stasis and left ethmoiditis were under treatment.

Laboratory Studies: Entirely negative.

X-ray examination: Hypertrophic arthritis of lower lumbar spine and sacro-iliac joints.

Previous Therapy: Salicylates and other symptomatic treatment, tonsillectomy, bowel hygiene and physiotherapy, paravertebral alcohol, nerve block, orthopedic surgery to spine and treatment of infected sinuses had all been without effect.

Treatment: Eight injections of chaulmoogra oil (5 cc. each), at weekly intervals.

Results: Patient claimed slight improvement after the fourth injection, but no definite improvement could be determined after the eighth injection.

In the following table we present the principal data from the entire series of the 65 cases of arthritis treated. (Table I.) We have recorded our results as follows: no improvement; slight, moderate and marked improvement and symptom free. We also present a table summarizing these results (Table II).

DISCUSSION

Of the 15 cases of *atrophic arthritis,* 13 or 87 per cent became symptom free. It is interesting to note that the two patients who were not rendered symptom free were the only two in our entire series who had evidence of rheumatic heart disease. One of these enjoyed moderate improvement. In the other the improvement was slight and all the symptoms returned two months later. Symptomatic improvement was remarkably rapid in all of the

patients responding to treatment. Eleven cases, or 73 per cent, showed definite subjective improvement after the third injection or two weeks after the injections were begun. The others all improved after the fourth or fifth injection. Three patients were symptom free after the fifth injection and all others after the eighth or following approximately 6 weeks' treatment. Objective joint changes were definite but more gradual. The soft tissue swelling and effusion decreased. Tenderness disappeared and joint mobility increased in all cases. The joint changes were usually accompanied by marked improvement in the general health.

The 33 cases of *mixed arthritis* responded in a more irregular manner to chaulmoogra oil therapy. This group contained many patients in whom the predominant symptoms were caused by atrophic joints. X-ray demonstration of slight hypertrophic changes in these or other joints made it necessary to classify them in the mixed group. Eighteen patients (55%) in this group were made symptom free, and fourteen (42%) showed moderate to marked improvement. Seventy-five individual joints studied were of the mixed type, and in these joints all clinical evidence of an atrophic process disappeared but the objective signs of hypertrophic arthritis remained. Considering the mixed pathology in these joints separately, the improvement noted corresponded roughly to the percentage of atrophic or infectious process present.

In *hypertrophic arthritis* the results were entirely unsatisfactory. Of the 17 patients treated, 11 or 65% failed to improve at all. Five showed slight and one moderate improvement. Of the six patients who improved nearly all had subsequent recurrence of symptoms. No objective changes were noted in any of the hypertrophic joints following treatment.

The sharp contrast noted in the results obtained is of considerable significance in the selection of cases for chaulmoogra oil therapy. There was practically no response in the hypertrophic group but there was excellent improvement in the mixed and atrophic types. Recurrence of symptoms in the mixed cases was not uncommon, however. The trauma induced by the associated hypertrophic changes may have been partially responsible for the return of symptoms.

We used chaulmoogra oil by mouth in only nine cases of arthritis and with no significant results. In two cases (Cases 28 and 31) there was no benefit. Some improvement followed its use in Cases 27, 35 and 47, but in the remaining four (Cases 4, 21, 14, and 49) the results were inconclusive. Hopkins and others used chaulmoogra oil orally at Carville for 15 years with distinctly favorable results in incipient leprosy. Doses of 50 to 150 gtts. daily were administered, however, and the patients frequently consumed as much as 5 or more liters of the oil during their course of treatment. Further use of this method of administration in larger doses and over a long period of time in atrophic arthritis should make an interesting study.

As we have already stated, we made no attempt to remove any foci of infection. Many of our outpatients had had extra-arthritic foci removed without relief before coming to our clinic. We did not find any relation between the presence or absence of foci and the results of the chaulmoogra therapy. The age of the patients and the duration of the symptoms also seemed to have no bearing upon the results obtained within the individual groups.

It was our experience that the degree of local reaction which the injection of chaulmoogra oil produced was not related to the degree of relief obtained. A few patients had a slight general reaction with moderate fever and leukocytosis after an occasional injection. These reactions were frequently accompanied by temporary exacerbation of the joint symptoms.

Conclusions

1. In a series of 65 cases of chronic nonspecific arthritis, intramuscular injections of chaulmoogra oil gave definite and marked symptomatic relief in the majority of those of the so-called atrophic type.

2. In cases of the hypertrophic type of arthritis, the oil had very little beneficial effect.

3. In the mixed type of arthritis, the beneficial effect of the oil is roughly proportionate to the degree of atrophic involvement of the joints, those cases in which the joint involvement was largely atrophic, being greatly relieved.

4. It is felt that the rapid and striking improvement which followed the injection of chaulmoogra oil in so many of our cases of the atrophic and mixed types of chronic arthritis justifies continued use of this drug until more specific therapeutic measures are found.

TABLE I
RESULTS OBTAINED WITH CHAULMOOGRA OIL INJECTIONS IN 65 CASES OF CHRONIC ARTHRITIS

Case No.	Age	Color Sex	Duration of Symptoms	Joints Involved	General Sympt. and other Diag.	Classification (On the Basis of Clinical and X-Ray Findings)	Total Number Injections	Improved After Inj. No.	Final Results	Comments
1	30	WF	5 yrs.	Fingers Wrists Elbows Knees	Nervousness Loss of weight Anemia	Atrophic	5	3	Symptom free	Recurrence 12 months later, following subsequent pregnancy. Again made symptom free after 2 injections.
2	55	WF	6 yrs.	Fingers Wrists Elbows Shoulders Knees	Nervousness Loss of weight Anemia Constipation	Atrophic	10	4	Symptom free	
3	39	CM	1 yr.	Fingers Elbows Knees Ankles	W. B. C. 13,000 Polys. 69% Sed. Ind. 58 mm.	Atrophic	8	3	Symptom free	
4	27	WF	2 yrs.	Fingers Wrists Hip		Atrophic	8	4	Symptom free	2.5 cc. chaulmoogra *orally* daily for one month between 5th and 6th inj. with slight benefit.
5	25	WF	2 yrs.	Fingers Wrists Elbows Shoulders Hips Knees	Nervousness Loss of weight Anemia Rheumatic Heart Disease Sed. Ind. 42 mm.	Atrophic	8	3	Moderate Improvement	Slight recurrence of symptoms in fingers. Continuing to work as typist.
6	21	WF	3 yrs.	Fingers Knees Ankles	Nervousness with marked tremors Anemia Rheumatic Heart Disease W. B. C. 10,000	Atrophic	8	3	Slight Improvement	Injections followed by 3 cc. chaulmoogra oil *orally* daily for 1 month. Recurrence of all symptoms 2 months later. Admitted to hospital for treatment as active rheumatic heart disease.
7	42	WM	1 mo.	Fingers Elbows Shoulders Hip	Loss of weight	Atrophic	6	2	Symptom free	Symptom free after 4th injection. Improved joint function after 6th injection.
8	60	WF	5 yrs.	Fingers	Nervousness Constipation	Atrophic	5	2	Symptom free	
9	39	CF	1 yr.	Wrists Knees Ankles Cervical spine	Anemia Constipation	Atrophic	8	5	Symptom free	Painful ankle relieved by correcting talipes valgus by wedging heel.
10	26	CF	2 yrs.	Fingers Wrists Elbow Foot	Syphilis	Atrophic	7	4	Symptom free	
11	31	WM	2 yrs.	Fingers Wrists Elbows Knee	Nervousness Anemia Loss of weight	Atrophic	7	3	Symptom free	
12	32	WF	5 yrs.	Fingers Wrists Elbows Shoulders Knees	Nervousness Anemia Loss of weight Constipation	Atrophic	8	3	Symptom free	

13	22	WM	2½ yrs.	Fingers		Atrophic	5	2	Symptom free	
14	25	WF	4 yrs.	Fingers Wrists Elbows Knees	Nervousness Anemia Loss of weight	Atrophic	8	4	Symptom free	3 cc. chaulmoogra oil *orally* daily for 5 days before injections. Discontinued because of gastric irritation.
15	38	WF	3 yrs.	Fingers Hip Lumbar spine		Atrophic	6	3	Symptom free	
16	40	CM	2 yrs.	Knees	Syphilis	Mixed	9	5	Symptom free	
17	36	WM	5 yrs.	Wrists Elbow Ankle		Mixed	8	4	Symptom free	Crepitus and some stiffness remain.
18	46	WF	4 yrs.	Fingers Knee Lumbar spine		Mixed	6	5	Marked Improvement	Backache not relieved.
19	38	WM	6 yrs.	Fingers Wrists Shoulder		Mixed	8	5	Symptom free	Crepitus remained.
20	69	WF	3 yrs.	Fingers Wrists Elbows Knees Shoulders Ankle		Mixed	5	3	Symptom free	
21	51	WM	4 yrs.	Wrist Hip Ankle Knees	Nervousness Loss of weight Weakness	Mixed	8	5	Moderate Improvement	
22	44	WF	18 mos	Fingers Knees	Nervousness Anemia	Mixed	8	4	Symptom free	After 6th injection marked improvement. Became symptom free one month later.
23	42	WF	5 yrs.	Fingers Hip	Fatigue Nervousness Anemia	Mixed	7		Marked Improvement	Hands symptom free. Hip pain improved and disappeared two months later.
24	36	WF	3 yrs.	Fingers Wrists		Mixed	5		Marked Improvement	
25	42	WM	4 yrs.	Fingers Wrists Knees		Mixed	6	3	Moderate Improvement	Crepitus remained.
26	34	WM		Back Hip Knee		Mixed	8	5	Symptom free	Recurrence of some backache three months later.
27	62	WM	2 yrs.	Lumbar spine Right sacroiliac joint Hip joint	Diabetes	Mixed	5	5	Symptom free	Recurrence 5 months later. Treated with one oral medication, 3 cc. daily for 2 months and again made symptom free. Patient developed increased carbohydrate tolerance.
28	46	WF	3 yrs.	Fingers Sacroiliac joint (Heberden's nodes)	Diabetes	Mixed	6		Symptom free	3 cc. chaulmoogra oil *orally* for 10 days before injections begun without benefit.
29	50	WF	1 yr.	Fingers	Leukopenia and Anemia	Mixed	6	2	Symptom free	

TABLE I (*Continued*)
RESULTS OBTAINED WITH CHAULMOOGRA OIL INJECTIONS IN 65 CASES OF CHRONIC ARTHRITIS

Case No.	Age	Color Sex	Duration of Symptoms	Joints Involved	General Sympt., and other Diag.	Classification (On the Basis of Clinical and X-Ray Findings)	Total Number Injections	Improved After Inj. No.	Final Results	Comments
30	70	CF	1 yr.	Fingers Spine Knees	Peripheral vasomotor changes	Mixed	8	2	Symptom free	Following first 2 injections patient became symptom free and treatment was discontinued. Recurrence in 4 months. Six more injections in 6 weeks and became symptom free. No recurrence in 6 mos.
31	59	WF	10 yrs.	Fingers (Heberden's nodes)	Nervousness Anemia Peripheral vasomotor changes Parietal neuralgia	Mixed	13	2	Marked Improvement	The maximum improvement was after the 4th injection. Six weeks *oral* medication, 3 cc. daily at this time, followed by 9 injections with no further improvement.
32	36	WM	7 yrs.	Knee		Mixed	3	3	Marked Improvement	Crepitus, swelling and limitation decreased.
33	35	WF	6 yrs.	Lumbosacral joint		Mixed	2	2	Marked Improvement	Failed to return for further treatment.
34	66	CM	4 yrs.	Lumbar spine Sacroiliac joint Knees	Parietal neuralgia	Mixed	8	3	Marked Improvement	Slight backache, the only remaining symptom.
35	50	WF	5 yrs.	Fingers Knees	Sedimentation Index 33 mm.	Mixed	10	5	Symptom free	3 cc. *by mouth* daily for 6 weeks. Improved after 5 days of oral medication and symptom free after 10 days. Recurrence in 6 weeks and made symptom free with 8 injections. Slight recurrence in 8 months and was made symptom free with 2 injections. No recurrence 8 months later.
36	34	WF	5 yrs.	Fingers Knees	Syphilis	Mixed	8	3	Symptom free	
37	58	WF	5 mos.	Lumbar spine Sacroiliac joint and Knee		Mixed	8	4	Symptom free	Crepitus remained.
38	57	CF	1 yr.	Elbows Shoulders Knees		Mixed	7	4	Symptom free	Marked crepitus.
39	84	WM	6 yrs.	Lumbar spine Sacroiliac and Lumbosacral joints		Mixed	5	3	Symptom free	
40	45	WM	3 yrs.	Fingers Elbows Shoulders	Constipation	Mixed	4		Marked Improvement	Failed to return for further treatment.
41	50	WF	6 yrs.	Wrists Cervical spine Knees Ankles	Nervous Depressed Loss of weight Constipation	Mixed	8	3	Symptom free	

42	67	CM	2 yrs.	Knees	Syphilis Sed. Index 41 mm.	Mixed	7	3	Symptom free	Crepitus remained.
43	56	CM	6 yrs.	Wrist Elbow Knee		Mixed	8	3	Moderate Improvement	
44	52	CF	5 yrs.	Fingers Wrists Elbows Hip Knee Ankles	Anemia Loss of weight	Mixed	8	4	Symptom free	
45	22	CF	2 mos.	One term. interphalangeal joint and Elbow		Mixed	3		Slight Improvement	Failed to return for further treatment.
46	55	WF	5 yrs.	Knees	Marked arteriosclerosis Hypertension Postural defects	Mixed	6	2	Marked Improvement	Heel was wedged to correct postural defect and remaining symptoms disappeared. No recurrence in 6 months.
47	53	WF	1 yr.	Fingers (Heberden's nodes) Knees		Mixed	3	2	Marked Improvement	Some tenderness in clenching fists, which disappeared after taking oral medication. Capsules produced sensation of "giddiness." No recurrence of symptoms in 3 months. 3 cc. by mouth daily for one week.
48	53	WF	1 yr.	Knees Lumbar spine	Myxedema	Mixed	8	2	Marked Improvement	Slight backache remained. Seven months later this disappeared.
49	59	WF	10 yrs.	Fingers Sacroiliac Lumbar spine	Sciatic-neuralgia	Hypertrophic	4		No Improvement	Injections preceded by 3 cc. chaulmoogra oil in enteric coated capsules for one month with no benefit.
50	65	WM	25 yrs.	Right knee		Hypertrophic	8		No Improvement	
51	57	CF	5 yrs.	Hands Knees		Hypertrophic	5	5	Slight Improvement	
52	56	WM	3 yrs.	Lumbar spine Sacroiliac joints	Parietal neuralgia in distribution of left 12th thoracic and 1st and 2nd lumbar	Hypertrophic	8	4	Slight Improvement	No further improvement after 4 remaining injections.
53	60	CF	15 yrs.	Knees Spine	Syphilis	Hypertrophic	8		No Improvement	Claimed some improvement after 4th injection, but symptoms quickly returned.
54	66	WM	15 yrs.	Lumbar spine		Hypertrophic	6		No Improvement	
55	48	CF	6 mos.	Shoulders Knee Ankle	Syphilis	Hypertrophic	6		No Improvement	Under treatment for syphilis.
56	49	CM	25 yrs.	Fingers Lumbar spine Hip Shoulder Ankles (Heberden's nodes)	Syphilis Parietal Neuralgia	Hypertrophic	8		Slight Improvement	Syphilis under treatment. Back not improved.

TABLE I (Continued)
RESULTS OBTAINED WITH CHAULMOOGRA OIL INJECTIONS IN 65 CASES OF CHRONIC ARTHRITIS

Case No.	Age	Color Sex	Duration of Symptoms	Joints Involved	General Sympt., and other Diag.	Classification (On the Basis of Clinical and X-Ray Findings)	Total Number Injections	Improved After Inj. No.	Final Results	Comments
57	70	CF		Lumbar spine and Knee		Hypertrophic	8		No Improvement	
58	47	WF		Cervical spine	Neuralgia right shoulder	Hypertrophic	6		No Improvement	
59	60	WM	20 yrs.	Knees		Hypertrophic	8		No Improvement	
60	48	CM	8 yrs.	Lumbar spine		Hypertrophic	6		No Improvement	
61	76	WM	10 yrs.	Fingers Lumbar spine Knees Ankles		Hypertrophic	6		Slight Improvement	Only improvement was in the fingers.
62	60	WM	6 yrs.	Wrist Spine Knees		Hypertrophic	5		No Improvement	
63	57	WM	25 yrs.	Lumbar spine Left sacroiliac joint		Hypertrophic	8		Slight Improvement	Recurrence of symptoms in two months.
64	55	CF	2 yrs.	Fingers Wrists (Heberden's nodes)		Hypertrophic	8		Moderate Improvement	
65	55	WF	10 yrs.	Knees		Hypertrophic	6		No Improvement	

TABLE II
SUMMARY OF RESULTS OBTAINED IN VARIOUS TYPES OF ARTHRITIS WITH CHAULMOOGRA OIL THERAPY

Types of Arthritis	No. of Cases	Average Age	No Improvement	Slight Improvement	Moderate Improvement	Marked Improvement	Symptom Free	Average No. of Injections of Chaulmoogra Oil
Atrophic	15	37	..	1 6.5%	1 6 5%	..	13 87%	7
Mixed	33	49	..	1 3%	4 12%	10 30%	18 55%	7
Hypertrophic	17	57	11 64%	5 30%	1 6%	..	.	6

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THEODORE F. HAHN, M.D.....*DeLand*
COUNCILL C. RUDOLPH, M.D.....*St. Petersburg*

ANNUAL GRADUATE SHORT COURSE

On Monday, June 27, 1938, the Sixth Annual Graduate Short Course for Doctors of Medicine will convene at the Osceola Hotel in Daytona Beach. The session will last one week as in the past. Daytona Beach was selected for the Course this year because the majority of the medical societies, in answering a questionnaire sent out by the committee, signified that this choice would be highly acceptable. The Osceola Hotel offers ample space for holding the meetings and attractive rates have been secured for the doctors who attend the Short Course. It is hoped that the physicians will bring their families and enjoy Daytona Beach's many recreational facilities, making the week one of relaxation and rest as well as one of educational value.

The members of the committee feel that the faculty this year is as distinguished a company as could be found in any medical center in the country. Dr. Beverley R. Tucker of Richmond, Dr. R. J. Crossen of St. Louis, Dr. Maurice C. Pincoffs of Philadelphia, Dr. Alexander J. Schaffer of Baltimore, Dr. J. O. Arnold of Philadelphia, and Dr. W. Emory Burnett of Philadelphia are included in the list of instructors. Arrangements for the symposium on "The Vitamines," to be held Tuesday evening, June 28, have not been completed; therefore the physicians who will appear then cannot be announced. Elsewhere in this issue of the *Journal* will be found biographical sketches of the members of the faculty.

The schedule this year is essentially the same as that of last year, the committee having found this to be the most practicable yet tried. On another page of this *Journal* the program is graphically presented with the exact time and title of each lecture.

In the five years of the Short Course's existence, more and more Florida doctors each year have availed themselves of the opportunity for postgraduate work at a minimum expenditure of time and money. Perhaps the most eloquent testimony of its worth is the fact that many return year after year.

Let's make the 1938 registration the best of all!

AN UNUSUAL COURTESY

For a dozen years the officers of the Florida Medical Association have been endeavoring to locate missing numbers of their Medical Journal, in order that a complete bound set might be available in the headquarters office for reference and research. Notices were run in many issues of the Journal, calling attention to the numbers that were missing. Many letters were written to the older members of the Association, to libraries and, as a last resort, to a number of companies who stock periodicals for sale. After every available means had been used to locate the missing issues, there were still 47 that could not be found, which was, of course, very discouraging.

Last month a very happy surprise occurred. The Library of the Jackson County

Medical Society of Kansas City, Missouri, offered to supply 45 of the missing issues of the Florida Medical Journal between the dates of 1914 and 1919. This was, indeed, an unusual courtesy. The library of this county medical society is very complete, with an efficient librarian. Through the efforts of Dr. Ira H. Lockwood, President of the society, and the librarian, Mrs. Elinor La Motte Chase, 45 of the old Journals of the Florida Medical Association have been received at the headquarters office of this Association. The file of Florida Medical Journals is now complete from volume 1 to volume 23 inclusive, with the exception of 2 journals, volume 1, number 12 and volume 2, number 11. The members of the Florida Medical Association are under lasting obligation to the Jackson County Medical Society of Kansas City, Missouri, its president, Doctor Lockwood, and the librarian, Mrs. Elinor La Motte Chase.

An urgent appeal is now made for the two missing numbers of the Florida Medical Journal: number 12 of volume 1 of 1915 and number 11 of volume 2 of 1916. Anyone knowing how or where these two copies of the Florida Medical Journal may be obtained, will please address Box 1018, Jacksonville, Florida.

ANNUAL CONVENTION—MIAMI

The Dade County Medical Society entertained royally the doctors and guests who attended the Sixty-Fifth Annual Convention of the Association. The meeting this year was held too late to permit the proceedings to be included in this issue of the Journal. The June Journal will contain a complete write-up of the Annual Convention and include new committee appointments by the president. Members of the Association are urged to read the June Journal carefully and thus become familiar with the actions of the House of Delegates, the various programs, scientific exhibits, reports of committees, entertainment, etc.

POSTGRADUATE LECTURERS



DR. J. O. ARNOLD

Returning to present the course in Obstetrics at the Short Course, June 27-July 2, will be Dr. J. O. Arnold whose lectures in this subject last year proved so popular. Dr. Arnold is Professor of Obstetrics at Temple University Medical School. He graduated from Jefferson Medical College in 1896. For seven years following graduation he was clinical instructor at Jefferson Medical College. In 1904 he joined the teaching staff of the recently organized medical school of Temple University where he was successively Instructor, Associate Professor, Clinical Professor, and, in 1927, Professor and head of the Department of Obstetrics.

Dr. Arnold is the author of a "Guide-Book in Practical Obstetrics" published in February, 1937, for hospitals and general practitioners, the "Temple Treatment" of Eclampsia, several series of "Obstetrical Review Clinics," and numerous other papers on obstetrics.

Many delivery room and other obstetrical instruments have been devised by Dr. Arnold, such as "Arnold Induction Tubes," "Cord Clamps," "Aspirator," 'Obstetrical Forceps," etc.



DR. BEVERLEY R. TUCKER

Dr. Beverley Randolph Tucker, who will come to Daytona Beach to present the course in Neuropsychiatry from June 27 through July 2, graduated from the Medical College of Virginia in 1905. After graduating he served an internship in the Infirmary of Nervous Diseases in Philadelphia and was an assistant of Dr. S. Weir Mitchell. During 1907 he did postgraduate work in New York, London, and Vienna, and entered the practice of medicine in Richmond in September, 1907, devoting his practice to neuropsychiatry. In 1908 he was invited to California and delivered a course of lectures on nervous disease at the medical department of Leland Stanford University.

Returning to Richmond Dr. Tucker served as adjunct professor at the Medical College of Virginia from 1907 to 1912, when a chair of nervous and mental diseases was inaugurated and he was made professor, a chair which he has since held. In 1938 Dr. Tucker will finish his 26th year as professor.

Dr. Tucker has served on the boards of the State Board of Health, the Virginia Industrial Home for Girls, the Children's Memorial Clinic, and the Richmond City Library. He has been president of the Tri-State Medical Association, the Seaboard Air Line Medical Association, and the Mental Hygiene Society of Virginia.

Dr. Tucker has contributed many papers on medical subjects. He has done notable research work in encephalitis, pellagra, von Recklinghausen's disease, pituitary disturbances, and other conditions. He wrote the section on pellagra for the British Medical Annual in 1914 and on cranial nerves and their diseases for *Tice's System of Medicine.* He published *Nervous Children,* a book, in 1916, and *Adolescence* in 1933. For six years he was editor of the Old Dominion Medical Journal. Besides his medical contributions he has published literary articles, plays, poems, and the following books: *A Brief Biography of S. Weir Mitchell, The Gift of Genius*—an analysis of 19 geniuses, and *Narna Darrell,* an historical novel.

A man of wide interests, Dr. Tucker is a member of the American Neurological Association, the American Psychiatric Association, the Pan-American Medical Association, the Board of the Nemours Foundation, and the Board of the American Hospital of Paris.

DR. R. J. CROSSEN

Dr. R. J. Crossen, Assistant Professor of Obstetrics and Gynecology at Washington University Medical School, has consented to present the course in Gynecology at the 1938 session of the Graduate Short Course, to be held in Daytona Beach, June 27 through July 2. Dr. Crossen graduated from Washington University Medical School in 1925. Formerly instructor of Obstetrics and Gynecology, he now holds an assistant professorship at his alma mater. He is on the staff of Barnes Hospital, St. Louis Maternity Hospital, Jewish Hospital, and DePaul Hospital.

Dr. Crossen is co-author with his father, Dr. H. S. Crossen, of the following books: *Diseases of Women, Operative Gynecology, Synopsis of Gynecology,* and *Gynecology for Nurses.*

DR. MAURICE C. PINCOFFS

Dr. Maurice C. Pincoffs, Professor of Medicine at the University of Maryland, will give the lectures on Medicine at the Short Course. Doctor Pincoffs received his B.S. at the University of Chicago in 1909 and spent the following year there as an assistant in anatomy. In 1912 he graduated from Johns Hopkins University School of Medicine, following which he was house officer at Presbyterian Hospital, Chicago, during the year succeeding. He was resident in Medicine at Baltimore City Hospitals from 1913 to 1915, when he became research assistant under Dr. John Abel and clinical assistant to Dr. L. F. Barker. From 1917 through 1919 Dr. Pincoffs served with the United States Army in France. Returning to this country in 1919, he became instructor in Medicine at Johns Hopkins University, a position which he held until 1922, when he accepted the professorship at the University of Maryland which he now holds.

Dr. Pincoffs is editor of the *Annals of Internal Medicine,* official publication of the American College of Physicians, and a member of the Board of Regents of that organization. He is a member of the Association of American Physicians, the American Clinical and Climatological Association, the American and Southern Medical Associations, the Johns Hopkins Medical Association, the Baltimore City Medical Society, the Maryland Mental Hygiene Society, and the Cosmopolitan and Eclat medical clubs.



DR. MAURICE C. PINCOFFS

DR. W. E. BURNETT

Dr. W. E. Burnett, who is scheduled to give the lectures on Surgery at the Short Course again this year, is well known to Florida physicians, having been Chief Surgeon, East Coast Railroad, 1929-1930. Dr. Burnett graduated from Jefferson Medical College in 1923 and following his internship of two and one-half years, he spent six months doing postgraduate work in Vienna, Paris, London and Edinburgh. At present he is Assistant Professor of Surgery, Temple University Medical School and Associate Surgeon at Temple University Hospital and Philadelphia General Hospital. He is a member of the American College of Surgeons.

Dr. Burnett's publications include 8 articles in the *Cyclopedia of Medicine,* (F. A. Davis Company), "Serum Treatment of Gas Gangrene," *Pennsylvania State Medical Journal,* 1932, "Rectal Drainage of Pelvic Abscess in Males," *Surgical Clinics of North America,* 1934, "Treatment of Perforative Appendicitis," *Delaware State Medical Journal,* 1934, "One-Stage Pneumonectomy under Local Anesthesia," *American Journal of Thoracic Surgery,* 1937, "Pulmonary Suppuration," *Pennsylvania State Medical Journal,* 1937, and "General Practitioner's Thoracic Surgery," *New England Medical Journal,* 1938.

SPECIAL NOTICE

For his "dry-clinic" on problem cases in every-day obstetrics, to be held at 11:30 o'clock, Thursday, June 30, Dr. Arnold wishes to use actual cases which have been experienced by Florida physicians. He requests that cases be described beforehand, so that they may be taken up at this time. Any member of the Medical Postgraduate Course committee will gladly receive these problems and see that they are turned over to Doctor Arnold.



DR. SCHAFFER RETURNING FOR PEDIATRICS COURSE

Another member of the faculty who is being brought back by popular request is Dr. Alexander J. Schaffer, who will present the course in Pediatrics at the Short Course. Dr. Schaffer graduated from Johns Hopkins School of Medicine in 1923. He was house officer at Harriet Lane Home, 1923-24; assistant resident, 1924-25; resident, 1925-26. He was chief dispensary pediatrician from 1926 to 1927. In 1925 he became Instructor in Pediatrics at Johns Hopkins School of Medicine, which position he held until 1936 when he became Associate Professor in Pediatrics.

Included among Dr. Schaffer's publications are "Treatment of Erysipelas with Blood Transfusion" and "Mikulicz' Syndrome," both of which appeared in the *American Journal of Diseases of Children* in 1927, "A Study of the Value of Convalescent's Serum in the Prevention of Measles," *Bulletin of the Buffalo General Hospital,* 1928, "Uveoparotid Fever as a Manifestation of Mikulicz' Syndrome," *American Journal of Diseases of Children,* 1928, "Etiology of Infantile Acquired Hemiplegia," with Dr. Frank Ford, and "Chronic Pyelo-Nephritis."

PROGRAM

Sixth Annual
Graduate Short Course
for Doctors of Medicine

Daytona Beach
June 27-July 2, 1938
Osceola Hotel

Sponsored by
Florida Medical Association
in cooperation with
The State Board of Health

MEETING PLACE

All sessions of the Short Course will be held at the Osceola Hotel, Daytona Beach, which is offering attractive rates to the physicians attending the Course and their families.

REGISTRATION

Registration will begin at 8:00 o'clock Monday morning, June 27. Anyone wishing to register ahead of time may do so through Dr. G. C. Tillman, Gainesville. A registration fee of $5.00 will be charged.

RECREATION

One of the reasons Daytona Beach was selected for the Short Course this year was the varied type of recreation it offers. It is the hope of the Committee that the doctors will bring their families and make the week one of rest and relaxation as well as study. In addition to the famous beach, those attending may enjoy golf, for there is a course adjoining the hotel, and fishing trips may be arranged if desired.

FACULTY

MEDICINE

Dr. Maurice C. Pincoffs, Professor of Medicine, University of Maryland School of Medicine, Baltimore.

SURGERY

Dr. W. Emory Burnett, Associate Professor of Surgery, Temple University Medical School, Philadelphia.

OBSTETRICS

Dr. J. O. Arnold, Professor of Obstetrics, Temple University School of Medicine, Philadelphia.

PEDIATRICS

Dr. Alexander J. Schaffer, Department of Pediatrics, Johns Hopkins School of Medicine, Baltimore.

GYNECOLOGY

Dr. R. J. Crossen, Assistant Professor of Obstetrics and Gynecology, Washington University School of Medicine, St. Louis.

NEUROPSYCHIATRY

Dr. Beverley R. Tucker, Professor of Neuropsychiatry, Medical College of Virginia, Richmond.

PROGRAM OF SIXTH ANNUAL GRADUATE SHORT COURSE

Hour	MONDAY June 27	TUESDAY June 28	WEDNESDAY June 29	THURSDAY June 30	FRIDAY July 1	SATURDAY July 2
8:00 a. m.	Registration Osceola Hotel					
9:00 a. m.	PEDIATRICS "What are the Pediatric Emergencies?" DR. SCHAFFER	PEDIATRICS "The Commoner Neurologic Problems of Pediatrics" DR. SCHAFFER	PEDIATRICS "The Anemias of Infants and Children" DR. SCHAFFER	GYNECOLOGY "Pelvic Infection. Endometriosis" DR. CROSSEN	GYNECOLOGY "Gynecological Endocrinology" DR. CROSSEN	GYNECOLOGY "Resume of Treatment and Prophylaxis of Malignancy of Uterus" DR. CROSSEN
10:00 a. m.	NEURO-PSYCHIATRY "How May Physicians Best Recognize Neuropsychiatric Conditions?" DR. TUCKER	NEURO-PSYCHIATRY "Psychoneurosis and the Emotion-Reason Balance" DR. TUCKER	OBSTETRICS "Practical Problems in Prenatal Care" DR. ARNOLD	SURGERY "Significance of Gastro-intestinal Hemorrhage" DR. BURNETT	SURGERY "The General Practitioner's Thoracic Surgery" DR. BURNETT	SURGERY "Hyperthyroidism" DR. BURNETT
11:00 a. m.	RECESS	RECESS	RECESS	RECESS	RECESS	11:00 - 12:00 OBSTETRICS "Wherein We ARE Making Progress" DR. ARNOLD
11:30 a. m.	MEDICINE "Functional Circulatory Syndromes" DR. PINCOFFS	MEDICINE "Obstructions in the Air Passages" DR. PINCOFFS	MEDICINE "The Toxicology of Certain Common Drugs" DR. PINCOFFS	OBSTETRICS "'Dry-Clinic' on Problem Cases in Everyday Obstetrics" DR. ARNOLD	OBSTETRICS "The Significance of Insignificant Signs and Symptoms" DR. ARNOLD	12:00 - 1:00 SURGERY "Infections of the Hand" DR. BURNETT
12:30 p. m.	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	
2:00 p. m.	NEURO-PSYCHIATRY "Encephalitis and Its Sequelae" DR. TUCKER	NEURO-PSYCHIATRY "Upper and Lower Motor Neuron Conditions" DR. TUCKER	NEURO-PSYCHIATRY "Convulsive States—Cause, Classification, and Care" DR. TUCKER	SURGERY "The Acute Abdomen" DR. BURNETT	SURGERY "Plastic Surgery in Daily Practice" DR. BURNETT	
3:00 p. m.	RECESS	RECESS	RECESS	RECESS	RECESS	
3:15 p. m.	MEDICINE "Heart Disease After Fifty" DR. PINCOFFS	MEDICINE "The Syndrome of Intravascular Hemolysis" DR. PINCOFFS	MEDICINE "The Preventive Aspects of Paralysis" DR. PINCOFFS	GYNECOLOGY "Retrodisplacement. Prolapse" DR. CROSSEN	GYNECOLOGY "Gynecological Endocrinology" (continued) DR. CROSSEN	
4:15 p. m.	RECESS	RECESS	RECESS	RECESS	RECESS	
4:30 p. m.	PEDIATRICS "Heart Disease in Infants and Children" DR. SCHAFFER	PEDIATRICS "Endocrine Therapy in Pediatrics" DR. SCHAFFER	OBSTETRICS "Prophylactic Measures in the Conduct of Labor" DR. ARNOLD	NEURO-PSYCHIATRY "The Newer Treatments in Neuropsychiatry: Hyperexia, Insulin Shock, Metrazol, and Narcotism" DR. TUCKER	OBSTETRICS "Eight Years of Experience in the Rational Treatment of the 'Toxemia' of Pregnancy" DR. ARNOLD	
8:00 p. m.		SYMPOSIUM "The Vitamines"				

CORRESPONDENCE

To the Editor—

FLORIDA'S HIGH MATERNAL MORTALITY RATE

As many of you know, Florida's Chambers of Commerce are always anxious to tell the world the many things in which Florida leads the nation. One thing which they have failed to mention, and one of which none of us are proud, is Florida's high maternal mortality rate.

We, the doctors of Florida, know that the blame is not entirely ours, yet we have to shoulder the responsibility and assume the blame, because to whom else can we "pass the buck"?

We know that it is largely due to the fact that the laws of Florida are so lax that anyone, no matter if he is a Medical Doctor, an Osteopath, a Chiropractor, a Naturopath, a Midwife, a Christian Science Practitioner, a kind neighbor, or some one who just happens to be passing by, can assume the responsibility of attending one of our Florida mothers through this important event of her life. It takes no experience to sign a birth certificate, but one has to be trained to be able to sign a death certificate.

We feel that we must put forth every effort to lower our appalling maternal death rate. This cannot be done until we learn more definitely the direct cause. Therefore the Committee on Maternal Welfare, in conjunction with the State Board of Health is beginning a survey. The details of this survey are to be carried out by the State Board of Health, through its Bureaus of Vital Statistics and Maternal and Child Health.

Whenever a maternal death is reported the physician reporting the death will receive a letter, notifying him that he will be called upon by a public health nurse, who has a questionnaire which will need his cooperation in filling out. There is not sufficient space on a legal death certificate for the information desired on these deaths; therefore the necessity for the questionnaire. We all realize that the questionnaire is valueless without complete cooperation between all parties concerned. If we do not cooperate fully the health authorities must assume that we have something to hide.

The survey must not be considered by anyone as a criticism. We all have maternal deaths, but for some reason Florida has more than its share. We must determine by this means, if it is due to the doctor, to the midwife, to others not equipped to practice good obstetrics, or to the patient who has neglected to seek good obstetric care.

If by this survey we learn that the care is not adequate or available, it must be made adequate and available. If we learn that those needing such care are not seeking it, then they must be taught to seek it and told where it can be obtained.

The plan is to carry on this survey over a period of years, making observations all along and if possible making corrections as mistakes appear.

So let me plead with you to cooperate with us in this great work, which I know will make it possible to save many mothers and babies who are needlessly being taken from us.

HOMER L. PEARSON, M. D., *Chairman*
Committee on Maternal Welfare.

STATE NEWS ITEMS

Dr. Charles W. Boyd and Dr. A. K. Wilson of Jacksonville recently took a postgraduate course in ophthalmology at the George Washington University, Washington, D. C.

* * *

Dr. Walter C. Page of Cocoa, Councilor of the South Central Medical District, was a visitor at the Association's headquarters in Jacksonville recently. Doctor Page is chairman of the Committee on Returns and Credentials of the Grand Lodge of Florida, F. and A. M. and, in this capacity, attended the annual meeting of the lodge, April 19 and 20.

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Dr. and Mrs. Raymond King of Jacksonville announce the birth of a daughter, Mary Katheryn, on April 15, at St. Vincent's Hospital.

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Dr. R. D. Thompson of Orlando, superintendent of the State Tuberculosis Sanatorium, was guest speaker at the weekly luncheon of the Jacksonville Exchange Club on May 4. He was introduced by Dr. Louie Limbaugh of Jacksonville.

Dr. H. Marshall Taylor of Jacksonville was principal speaker at the April meeting of the John Gorrie Parent-Teacher Association. He presented a moving picture on "The Hygiene of Swimming" and discussed the dangers connected with this sport.

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An addition of 17 rooms is being built to the Joseph Halton Hospital in Sarasota. This fine addition will permit more adequate care than is possible at present.

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Dr. Edward Jelks of Jacksonville was principal speaker at a meeting of the Woman's Club of Jacksonville on April 13. His subject was "Some Aspects of Socialized Medicine."

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Dr. Charles W. Folsom of Miami and Mlle. Louise Lacroix of Paris were married aboard ship in mid-Atlantic on April 20. The marriage was performed by Capt. Reginald Rose of the liner, City of Norfolk.

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Dr. Thomas M. Palmer of Jacksonville was principal speaker at the April meeting of the Parent-Teacher Association of Landon High School. His lecture dealt with health matters of particular interest to parents.

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The radio broadcasts of the American Medical Association during the coming month will feature "Using Health Knowledge." This group will be the last of the present series of broadcasts which began on October 13, 1937. All are scheduled for 2:30 p. m., over the Red network of National Broadcasting Company.

May 25—The Health Check-Up. Periodic health examination and what follows, and why.

June 1—Vacation Plays and Misplays. Making the vacation a real contribution to health and recreation.

June 8—Graduation and Then What. A new phase of life begins at commencement, and health contributes to success.

June 15—What Medicine Offers for Health. Flashes from the American Medical Association meeting at San Francisco, giving highlights of medical progress.

Friends of Dr. L. E. Bransford of Jacksonville will regret to learn of the death of his wife on May 13, 1938, in a Jacksonville hospital, following a long illness.

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Dr. J. H. Mills' new address is 910 East Columbus Drive, Tampa.

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Dr. C. P. Bullard of Miami announces the removal of his office to 3924 N. W. 7th Avenue, where he has planned and constructed his own building.

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Dr. Kenneth A. Morris of Jacksonville attended the meeting of the Southern Society of Clinical Surgeons in Montreal, April 25-28.

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Dr. A. L. Huskey of Chattahoochee resigned from the staff of the Florida State Hospital and, on May 1, assumed a position on the resident staff of Grady Hospital, Atlanta.

* * *

Dr. and Mrs. O. A. Schaeffer of Coral Gables recently returned from three weeks spent in Chicago and Philadelphia, where Doctor Schaeffer attended clinics.

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Dr. M. J. Henderson has established his office in the Stephen Foster Hotel Building, Live Oak, where he will do general practice.

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Dr. L. S. Laffitte of Jacksonville was the principal speaker at the final meeting of the Norwood Parent-Teacher Association of Jacksonville, held May 12. Doctor Laffitte's subject was "Tuberculosis in Children."

* * *

Dr. O. W. Jenkins of Chattahoochee has resigned his position at the Florida State Hospital and returned to his former home in Georgia where he will enter private practice.

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Dr. Herbert R. Mills of Tampa has been certified by the American Board of Pathology, in pathologic anatomy and clinical pathology.

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Dr. and Mrs. Herbert L. Bryans and Dr. and Mrs. J. N. McLane of Pensacola attended the annual meeting of the Alabama Medical Association in Mobile, April 19-21.

Dr. Estella G. Norman of Miami Springs sailed April 14 for Europe. She will visit England, France, Germany, Italy and Switzerland before returning June 1.

* * *

Thirteen members of the Florida Medical Association attended the Twenty-second Annual session of the American College of Physicians which was held in New York City, April 4-8:

W. C. Blake, Tampa
James L. Borland, Jacksonville
H. L. Bryans, Pensacola
Turner Z. Cason, Jacksonville
W. Wellington George, West Palm Beach
Theodore F. Hahn, Jr., DeLand
Robert M. Harris, Miami
Louis M. Limbaugh, Jacksonville
Meredith Mallory, Orlando
J. Webster Merritt, Jacksonville
Kenneth Phillips, Miami
Charles F. Roche, Miami Beach
William H. Walters, Miami

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The oral, clinical and pathological examinations for Group A and Group B applicants will be held in San Francisco, California, on Monday and Tuesday, June 13 and 14, 1938, by the American Board of Obstetrics and Gynecology. Application blanks and booklets of information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

* * *

Dr. and Mrs. Charles W. Boyd of Jacksonville announce the birth of a son, Charles W. Boyd, Jr., on April 26, in Riverside Hospital.

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FOR SALE—At Winter Park, Florida, medical and surgical practice established 14 years in beautiful resort and college town of 5,000 population which doubles during winter season. Annual minimum income, $15,000; collectible, 95%. Two accredited hospitals in adjoining city of Orlando. Location includes long lease on building, with all equipment and library complete. Will accept best cash offer; immediate occupancy. Address Box 834, Winter Park, Florida.

* * *

WANTED: 1 Bickham's Operative Surgery, second hand in good condition.

WANTED: 2 Florida Medical Journals: June, 1915—Vol. 1, No. 12; May, 1916—Vol. 2, No. 11.

WANTED: 1 volume of Index Medicus, 1924.

Dr. and Mrs. F. H. Schnauss of Jacksonville announce the birth of a son, Friederich Wilhelm II, on May 9, in St. Luke's Hospital.

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Dr. John C. Knight of Plant City died at his home on March 6, 1938, at the age of 66, following a heart attack.

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Dr. Charles H. Field of Bradenton died on April 18, 1938.

CALVIN D. CHRIST

Dr. Calvin Daniel Christ, one of Florida's most outstanding surgeons, died in Orlando, March 20, 1938, very suddenly.

Doctor Christ began the practice of medicine in Orlando in 1906 and was one of the organizers of the Orange County Medical Society. He was also a member of the Florida Medical Association, the Southern Medical Association, and the American Medical Association. He was surgeon for the Seaboard Airline Railway in Orlando, and in 1930 was offered the position of Chief Surgeon of the entire Seaboard Airline Railway System.

Doctor Christ was born in Hughesville, Maryland, October 16, 1878, the son of Mr. Henry Christ and Caroline Hoffman Christ. He is survived by his widow, Elizabeth Abbott Christ, to whom he was married in Moorstown, New Jersey, April 29, 1911, and one son, George Abbott Christ.

He received his early education at Charlotte Hall School, St. Mary's County, Maryland, and graduated from this institution with honors on June 30, 1898. He then entered the College of Physicians and Surgeons in Baltimore to pursue the course of his life's ambition to become a physician, and graduated in May, 1905. Thereafter, he entered the Presbyterian Eye, Ear, Nose and Throat Charity Hospital as resident physician from May, 1905, to March 1, 1906. Because of his health, he was advised to go to Florida, where he passed the examination of the Florida Board of Medical Examiners, May 1, 1906, and began the practice of medicine in Orlando as an associate of the late Doctor Harris. After about a year, he decided to open an office for himself. From his earliest efforts, he demonstrated his ability and became one of the out-

standing physicians in central Florida. He was a regular attendant of the International Clinic where the learned of all lands were accustomed to assemble, and at these clinics both gave and received information in medicine. On several occasions, he resorted to self-inspired methods to accomplish unusual results. He loved the outdoors, and places where they played the games of yesterday. He served as County Physician for many years, and was also City Physician for several years.

Doctor Christ was president of the Orange County Medical Society in 1912, and served as a vice-president of the Florida Medical Association in 1918. He was President-elect of the Florida Railway Surgeons Association when he died, and was chief of the Medical Patriarchs of Florida.

In the passing of Doctor Christ, the medical profession lost one of its most valued and beloved members. His life's work is done; his experiences are ended, and all can say, "He was a humble physician." He would ask no greater name than that. It was what he sought from the beginning.

This brave and tender man stood many storms throughout life, but always emerged smiling. His heart was wrung by the sight of suffering, and he had tears for the erring and oppressed. He had the love that gave for the joy of giving, asking nothing in return. If he could have expressed himself as he was leaving us, he would have said, "I know not where I go, but I am not afraid. All I ask is a greater understanding." So —

"Under the wide and starry sky,
Dig the grave and let me lie.
Glad did I live, and gladly die
And I laid me down with a will.

"This be the verse you gave for me—
Here he lies where he longed to be.
Home is the sailor, home from the sea,
And the hunter home from the hill."

ROBERT LOUIS STEVENSON.

Man is neither master of his life nor of his fate. He can offer to his fellowman his efforts to diminish human suffering; he can but offer to God his indomitable faith.

So, whereas the passing of this beloved member of this Medical Society has brought grief and sorrow to its members, therefore be it resolved

That the Orange County Medical Society express its sorrow in the passing of Doctor Christ and extend its sympathy to the bereaved family; that this resolution be spread upon the minutes of this society as a reminder to us, and be published in the Florida Medical Journal.

T. A. Neal, M. D.
Frank Gray, M. D.
W. H. Spiers, M. D.

B. AUXFORD BURKS

Bennette Auxford Burks was born in Tuscaloosa County, Ala., January 24, 1883, the oldest of four children of Henry Thomas Burks and Amanda Jerusha Auxford. He was descended from pure English stock of pioneer American families of the south who were prominent in Virginia and the Carolinas before and during the American Revolution.

Doctor Burks was educated at Sewanee, the University of Alabama and the University of Michigan, receiving his M. D. in 1910. He had practiced medicine continuously since that time. In 1912 he married Mary Katherine Ward of Eutaw, Greene Co., Alabama. He spent two years in France as regimental surgeon with the 317th Infantry of the 80th Division. During the services held at Rollins Chapel, the casket was covered with a Red Cross flag which, still marked with the mud of the battlefields, was used all through the World War by Doctor Burks to mark the First Aid stations of the regiment with which he served in battle.

At the conclusion of the war he was sent to the University of Lyon, Lyon, France, for six months' postgraduate medical course. He spent nine years following the war in U. S. P. H. S., meantime taking postgraduate work in leading clinics and hospitals in the United States. He retired from the government service and came to Winter Park in 1925 where he spent the succeeding years in practice, numbering among his friends and patients many of the celebrated people who make this city their winter home. He had served for the past 12 years on the staff of Rollins as college physician. He was decorated last Commencement for services to Rollins College.

He was a member of the Orange County Medical Society, the Southern Medical Association and a Fellow of the American Medical Association as well as a Reserve Officer in the U. S. Army Corps. He was a member of the Winter Park Chamber of Commerce and the Winter Park University Club; also of the Orlando Country Club and the University Club; the ATO Fraternity and Phi Chi medical fraternity.

He is survived by two brothers and one sister and their families in Alabama and a large family connection throughout the South and by his widow and one daughter. At his final request his body was cremated and the ashes will be interred in the family plot at Tuscaloosa, Alabama, at a later date, at which time and place services will be held for the immediate family.

"Tenderness and blessings followed in his footsteps,
Richer were the friendships, happier the households, wheresoe'er he came.
Little children loved him
And he left behind him in the hour of parting
Memories of kindness and a God-like name."

PAUL EATON

Dr. Paul Eaton, until recent months Director of Laboratories, Florida State Board of Health, died in Jacksonville, February 25, 1938.

Doctor Eaton was born in Weston, West Virginia, on June 18, 1875. He graduated from the Allegheny College, Meadville, Pa., in 1899 and from the University of Pittsburgh Medical School in 1903. He received the degree of Doctor of Public Health from the University of Georgia in 1926.

Following his graduation, Doctor Eaton was actively engaged in private and hospital practice for eleven years. Since that time he engaged in various activities in relation to public health and allied research, a portion of which was accomplished as a medical officer in the United States Public Health Service. In this Service he did notable work in the Plague Laboratory at Beaumont, Texas, and in soil pollution studies with Dr. C. W. Stiles at Fort Caswell, North Carolina. From 1918 to 1920 he was Instructor of Bacteriology at Johns Hopkins and, from 1922 to 1925, Instructor of Hygiene and Public Health at Harvard Medical School. From 1925 to 1929 he held the chair of Associate Professor of Preventive Medicine and Acting Head of the Department of Preventive Medicine of the University of Georgia.

Doctor Eaton then became Director of Laboratories of the Florida State Board of Health which position he held for seven and one-half years, until his failing health forced his retirement. He was largely responsible for the development of the laboratories to their present state of efficiency and of valuable service to the medical and public health professions and to the public.

Among Doctor Eaton's contributions to medical and scientific literature were: "The Coeliac Axis"; "A Method for Determining the Life Duration of the Erythrocyte, the Rate of Red Cell Production after Hemorrhage"; "Quinine and Malaria"; and "Susceptibility of Red Cells to Malaria". In the latter publication he drew attention to the susceptibility of the reticulocytes rather than the old erythrocytes to invasion by the marozoites. Another work of Doctor Eaton, "Piroplasma Canis in Florida", has been recognized as the first report of Canine Babesiasis (Piroplasmosis) in the continental United States. Doctor Eaton was a profound student not only in the medical sciences but in general literature and current affairs. He left an indelible imprint upon many students and men of science with whom he came in contact.

Doctor Eaton was a member of the Duval County Medical Society, the Florida Medical Association, the American Medical Association, Florida Public Health Association, American Public Health Association, American Society of Tropical Medicine, Southern Medical Association, American Association for the Advancement of Science, Sons of the American Revolution (Jacksonville Chapter), and the Lions Club of Jacksonville.

Survivors are his widow, Mrs. Mary Wright Eaton; a son, William Wright Eaton of Rochester, N. Y.; a brother, Oliver K. Eaton, an attorney of Pittsburgh; and a sister, Mrs. W. A. Weldin of Pittsburgh.

JOHN CLARENCE KNIGHT

At the last regular meeting of the Hillsboro County Medical Society the following resolution was adopted.

WHEREAS, God in His infinite wisdom has seen fit to remove from our membership our beloved pioneer colleague, John Clarence Knight, M. D., and

WHEREAS, we, the members of the Hillsboro County Medical Society, do hereby feel his loss as a friend, councilor and beloved brother practitioner, therefore,

BE IT RESOLVED, That the Hillsboro County Medical Society express its grief and heartfelt sympathy to his bereaved family, and furthermore,

BE IT RESOLVED, That a copy of this resolution be sent to his family, spread on the Minutes of the Hillsboro County Medical Society, and published in the Florida Medical Journal.

J. W. Alsobrook, M. D.,
J. A. Coleman, M. D.,
T. C. Maguire, M. D.

LEONIDAS M. ANDERSON

In the passing of Dr. L. M. Anderson on January 21st, 1938, organized medicine, and especially we of the Suwannee River Medical Association, have experienced a distinct loss. Dr. Anderson, perhaps more than anyone else, was responsible for the birth of the Suwannee River Medical Association, and his interest in its welfare lasted until his death. Therefore, as an expression of our love and appreciation for Dr. Anderson, we spread this memorial on our minutes, and send a copy of this resolution to the members of Dr. Anderson's family, and to the Journal of the Florida Medical Association.

R. B. Harkness, M. D.,
W. M. Ives, M. D.,
Committee.

COMPONENT COUNTY SOCIETIES

DUVAL COUNTY MEDICAL SOCIETY

The regular meeting of the Duval County Medical Society was held in the State Board of Health Building, May 2 at 8:15 p. m. The scientific program was composed of three papers: "The Part of the General Practitioner in the Fight Against Syphilis" by Dr. Adolph Jacoby of New York, who was guest speaker; "The Value and Significance of the Tuberculin Test" (illustrated) by Dr. A. J. Logie; and "The Advantages of Fluoroscopic Control in Reduction of Certain Types of Fractures" (illustrated) by Dr. T. H. Lipscomb. Dr. W. McL. Shaw led the discussion.

* * *

ORANGE COUNTY MEDICAL SOCIETY

THE ORANGE COUNTY MEDICAL SOCIETY, WITH A MEMBERSHIP OF 70 ACTIVE AND 2 HONORARY MEMBERS, STANDS 100% PAID FOR 1938. CONGRATULATIONS! THIS SOCIETY IS HEADED BY DR. H. A. DAY, PRESIDENT; CARL D. HOFFMANN, VICE-PRESIDENT; HEWITT JOHNSTON, SECRETARY; AND RUSSELL B. CARSON, TREASURER.

The April meeting of the Orange County Medical Society was held Wednesday evening April 20, at the State Tuberculosis Sanatorium, Orlando. A special Tuberculosis program was presented, as follows:

I. Dr. R. D. Thompson
   (a) Incidences in Florida—Orange County
   (b) Presence of Tuberculosis—White and Colored
   (c) Diagnosis; History, Physical and Laboratory

II. Dr. L. H. Kingsbury
   Minimals
   Tuberculin Test; X-rays and careful taking of histories; X-rays of Minimal Types we have received to be shown and discussed.

III. Dr. H. H. Brueckner
   Ages in Tuberculosis—All ages
   X-rays of the youngest and oldest patients in the Institution, giving in brief a part of the history of each case, particularly the contact history

IV. Dr. W. O. Fowler
   Far Advanced Types. Several films to be shown of far advanced types and a few words in regard to the history as to length of illness and contact

V. Dr. Roger J. B. Hibbard
   Occupations—Several films to be shown of different people representing different occupations with relation particularly to those handling food and those living with children

VI. Dr. R. D. Thompson
   Unusual cases — Pulmonary Lesions — Films, Silicosis, Malignancy, Bronchiectasis and Congenital Cystic Degeneration of Lung

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

The Pasco-Hernando-Citrus County Medical Society was entertained by Dr. S. C. Harvard at its regular meeting held Thursday evening, April 14, at Brooksville. Dinner was served at the Tangerine Hotel. The scientific program consisted of interesting case reports by Doctors Bradshaw, Harvard, Harrell, Jones and Walters.

The society went on record as agreeing to assist the American Society for the Control of Cancer in every way possible. Doctors present at this meeting were J. T. Bradshaw, A. C. Coogler, G. R. Creekmore, S. C. Harvard, H. L. Harrell, W. Wardlaw Jones, and William H. Walters.

Dr. W. Wardlaw Jones invited the society to meet with him in Dade City on May 19.

* * *

PINELLAS COUNTY MEDICAL SOCIETY

At the May 6 meeting of the Pinellas County Medical Society, Dr. W. M. Davis was principal speaker. His subject was "Did You Know?"

* * *

PUTNAM COUNTY MEDICAL SOCIETY

The Putnam County Medical Society held its regular meeting Tuesday evening, April 5 in Palatka. Present were Drs. H. A. Johnson, Joseph E. Rose, Emory Bell, Edward W. Ford, C. M. Knight and Allen P. Gurganious. Dinner was served at the Marion Hotel, after which moving pictures of an operation for depressed skull fracture and a colostomy were shown. The president of the society, Dr. Z. Brantley, was unable to attend, due to illness.

A special meeting of the society was held at 7 p. m. on April 19 at the Marion Hotel. After dinner, Dr. A. B. McCreary of the State Board of Health, discussed the county health unit and urged that Putnam County join with Bradford and Clay Counties to obtain such a unit.

* * *

VOLUSIA COUNTY MEDICAL SOCIETY

The April meeting of the Volusia County Medical Society was held at Stetson Commons, DeLand. A symposium on "Cancer" was presented by Drs. J. Ralston Wells, Evans B. Wood, and Maximilian Stern. Twenty-one doctors and sixteen ladies were present at the chicken dinner which followed the meeting.

ABSTRACT DEPARTMENT

Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.

Visual Standards for Licensure to Operate Motor Vehicles—BLACK, NELSON M., Miami; GRADLE, H. S., Chicago; and SNELL, A. C., Rochester, N. Y. J. A. M. A. 109:61B-63B (Oct. 16) 1937.

This article represents a preliminary report of a special committee, made at the Atlantic City Session of the American Medical Association in 1937. Due to the high fatality and mortality rate (38,500 deaths and 110,000 permanent injuries in 1936) methods of control and prevention are required, including faulty mechanisms, road conditions, physical and mental defects of the driver, and the psychology of driving.

The section on ophthalmology of the American Medical Association is interested in the visual phase of the problem of physical defects in drivers because the driver alone is responsible for three-fifths of all accidents. Of course visual function cannot be separated from the physical and mental, but good vision is essential to obtain transmission and interpretation of sensory impressions. So the following recommendations were made:

1 Bureaus of licensure to be established to determine ability and efficiency of drivers.

2 Unlimited and limited licenses shall be issued after tests, depending on whether the candidate has defects or certain minimum defects which are given in detail.

3 Visual tests and standards, outlined in detail.

4 Minimum visual standards for licensure, outlined in detail.

5 Visual standards for the obtaining of a limited license, outlined in detail.

6 Standards for renewals, re-testing and re-examinations, outlined in detail.

The standards outlined, and the tests to be made, shall be under the control of the licensing bureaus, which shall have access to ophthalmological experts for final decisions in questionable cases. Consulted in regard to standards were: Council of State Govern-



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ments, National Safety Council, American Automobile Association, National Association for the Prevention of Blindness, Bureau of Legal Medicine of the American Medical Association, United States Department of Commerce, National Bureau of Standards, National Research Council, and numerous students of traffic problems.

Transportation of Rheumatic Fever Patients to a Subtropical Climate—Jones, T. Duckett, and White, Paul D., Boston; Roche, C. F., Perdue, Jean Jones, and Ryan, H. A., Miami Beach, J. A. M. A. **109**:1308-1310 (Oct. 16) 1937.

Since 1930, twenty-six patients have been transported from the House of the Good Samaritan, Boston, to the St. Francis Hospital in Miami Beach. Groups of four to six are sent each year and remain for a six to eight-month winter period. Five of these have had two winter seasons. Conditions and therapy are comparable in both places.

Three patients died in Florida, in eleven the rheumatic fever became quiescent, in nine there was definite improvement, five were unimproved, and two were worse. Recurrences occur in Florida after sore throats, colds, unexplained fever and without precipitating events. Since returning to Boston, eight have remained well and twelve have had recurrences. Protection afforded by stays in Florida seemed variable and caution is expressed as to unquestionable value of transportation of rheumatic fever patients to a subtropical climate.

Discussion of the paper by Drs. W. D. Stroud, M. J. Shapiro, Arthur DeGraff, H. F. Swift, May G. Wilson, W. P. Holbrook, E. S. Nichol, E. F. Bland and T. D. Jones gives the general impression that transportation of rheumatic fever patients to a subtropical climate is not as productive of results as one would hope for and not worth the economic burden imposed for questionable value received, for recurrences on return home are frequent, recurrences in subtropical climates are seen too frequently, and no studies exist to show much lengthening of life in these subjects transported.

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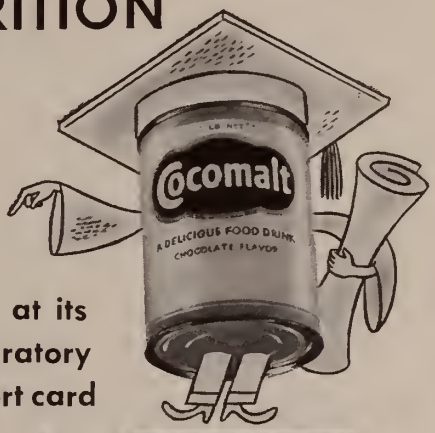
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Injection Treatment of Hernia—BUTLER, PAUL T., Orlando, *Am. J. Surg.* **37**:256-262 (Aug.) 1937.

Butler reviews the anatomy of the various hernias and stresses the need for accurate anatomical knowledge in the treatment of hernia by the injection method.

Physiologically, the injection of mildly irritating solutions into the muscles and fascia is characterized by early edema of tissues and exudate of plasma. Later this is replaced by fibroblasts which develop into young fibrous tissue and then, in about 2 weeks, mature fibrous tissue.

The wearing of a suitable truss day and night during the period of treatment is essential to its success.

Contraindications include advanced tuberculosis and nephritis, hopeless diabetes and persistent asthma.

The author's technique involves the careful injection of (1) 2.5 cc. of procaine solution directly into the fascia. (2) After 10 minutes and with the needle still in situ 3 cc. of a proliferating solution is injected. (3) This is followed immediately with a .5 cc. of the procaine solution in order to clear the needle of any remains of the proliferating preparation which would otherwise cause irritation to the fatty and subcutaneous tissues during the withdrawal of the needle.

Injections are repeated at 2 to 3 day intervals. The number if injections varies but is usually from 5 to 10.

The obvious advantages of this method over operative procedures lie in the fact that the patient is ambulatory and that the procedure is practically free from danger.*

---

*EDITOR'S NOTE: *A summary of the history of the injection treatment of hernia (1837-1937) may be found in the appendix of the* YEAR BOOK OF GENERAL SURGERY *for 1937. The following quotation is made by Graham at the beginning of this article: "As 1937 is the centenary of this fashionable procedure, it seemed of interest to glance briefly at its history. Previous articles have many discrepancies and anachronisms; the present one is founded on the original essays." Velpeau first hit on the plan in 1837, and the injection treatment was revived at intervals until 1937. The injection treatment undoubtedly deserves serious consideration, but it should be remembered that the majority of the medical profession still believes operation to be the simplest, shortest, and safest form of treatment.*



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(New officers next issue)

NEW AUXILIARY ORGANIZED

Under the guidance of our President, Mrs. S. M. Copeland, and Dr. Gordon Ira, chairman of the Advisory Board to the Woman's Auxiliary, together with Mrs. Gordon Ira, our secretary-treasurer, Lake County joins our auxiliary ranks. The officers are: president, Mrs. Leroy Henry Oetjen, Leesburg; vice-president, Mrs. C. M. Tyre, Eustis; treasurer, Mrs. L. R. Bowen, Eustis.

* * *

Our valuable member, Mrs. J. Ralston Wells, who has served ably in many capacities, recently as editor of the Auxiliary Page and at present as State Commander of the Woman's Field Army for the Control of Cancer, has been elected President of the Florida Federation of Woman's Clubs. Congratulations.

* * *

LETTER FROM THE RETIRING PRESIDENT

NATIONAL MEETING

At this time I am anxious to call attention to the annual meeting of the American Medical Auxiliary to be held in San Francisco, June 12-17. The Hotel Jairmont will be headquarters; all reservations must be made through Dr. F. C. Warnshuis. Plans are going forward rapidly to make the convention one of unforgettable inspiration, and I trust that you will realize the importance of sending capable, interested and enthusiastic delegates!

I hope that it will be possible for the president-elect of our state to attend, as well as

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SURGERY—General Courses One, Two, Three and Six Months: Two Weeks Intensive Course in Surgical technique with practice on living tissue; Clinical Courses; Special Courses. Courses start every Monday.

GYNECOLOGY—Personal Courses May 2, June 13, August 22. Gynecological Pathology by Dr. Schiller, starting July 25.

OBSTETRICS—Two weeks intensive course starting June 6; Informal Course starting every week.

FRACTURES AND TRAUMATIC SURGERY—Informal Course; Intensive Formal Course starting June 6.

UROLOGY—One Month Course; Two Weeks Course starting every two weeks.

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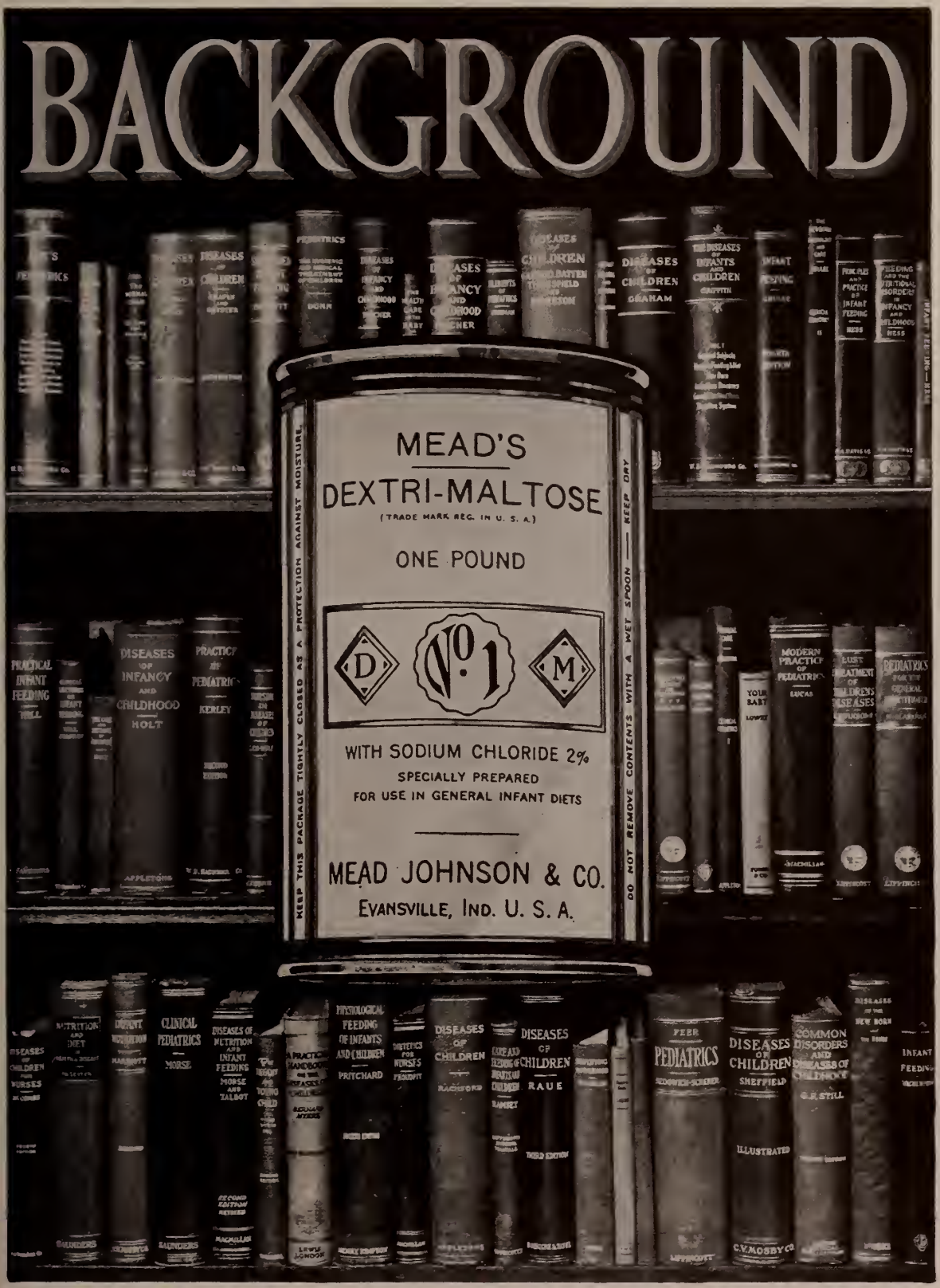
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the president, since experience has shown that presidents-elect are fitted for a better administration as a result of the education and inspiration of a great national meeting. A cordial invitation is extended to every Auxiliary member, whether or not she holds any official position in the work. We feel that much help and inspiration will come from meeting others from all over the nation, and hearing what they are doing.

As this notice goes to press, I am reminded that this will be my last official message to you, my officers and members, and I desire to again express my profound appreciation for the sympathetic understanding and helpful co-operation which has been accorded me during my term as your president, and to bespeak for my successor, Mrs. Arthur Walters of Miami, a pleasant and prosperous period of tenure. With all good wishes for your future success and hoping that you may give to Mrs. Walters the same loyalty and support that you have given me, I am

Faithfully yours,

MINNIE R. COPELAND, (Mrs. S. M.)

President.

* * *

NEWS LETTER

In the March publication of the Woman's Auxiliary to the American Medical Association, honorable mention is accorded Pinellas County and Duval County, Florida, among fifteen others, in the National Hygeia Contest which closed January, 1938. Mrs. I. J. Strumpf is Hygeia Chairman for Duval and Mrs. E. A. Heibner for Pinellas. The three prize winners are auxiliaries of Pinal County, Arizona; Berks County, Penn.; and Cook County, Illinois.

Under the heading of "State Auxiliaries, Articles by Presidents," follows an inspiring report of the efforts and concrete results accomplished by the Florida auxiliaries, turned in by your president, Mrs. S. M. Copeland.



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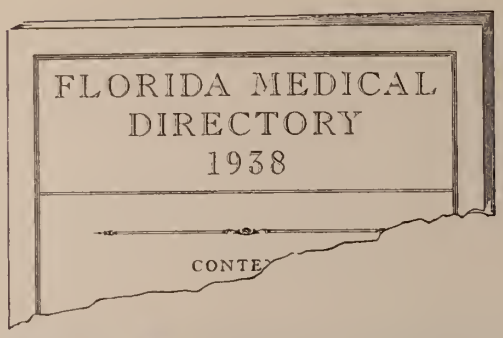
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WHY A DIRECTORY?

The Florida Medical Directory is compiled and issued to acquaint its users with the personnel of the medical profession of the State of Florida. It is hoped that the publication will be of such practical value that you will use it daily. Learn the value of the book by using it whenever you want facts concerning a physician not well known to you. To what sanitarium can I send a patient? Who is the author of this article in my Journal? Who is the physician who has called me in consultation? Who is the physician anywhere who wants me or whom I want? Is the new doctor practicing in my locality a member of the State Association? Does Doctor So-and-So have a Florida license?

The names of doctors holding Florida licenses are arranged in alphabetical order in one section. In another section the names are arranged by cities, states and foreign countries. In still a third section the names and addresses of members of the Florida Medical Association appear. A limited number of copies of this first edition of the Florida Medical Directory has been ordered from the printer. Place your order now, before the supply is exhausted.

FLORIDA MEDICAL ASSOCIATION
P. O. Box 1018
JACKSONVILLE, FLORIDA

Please send me one copy of the first edition of the Florida Medical Directory. Enclosed is One Dollar ($1.00).

NAME .....

ADDRESS .....

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COMPONENT SOCIETIES BY DISTRICTS—FLORIDA MEDICAL ASSOCIATION

Districts	COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR *and Counties Not Included in First Column*	Members Total	Members Paid
Northwest District (A) Panama City July 14, 1938	Bay	W. J. Blacksbear, M.D., Panama City	William C. Roberts, M. D., Panama City		A-1-'40 Carol C. Webb, M. D., Pensacola	11	9
	Escambia	J. M. Hoffman, M. D., 1221 E. DeSoto St., Pensacola	J. N. McLane, M. D., 204 W. Brainard St., Pensacola	2nd Tuesday 8:00 P. M.		41	33
	Walton-Okaloosa	A. G. Williams, M. D., Lakewood	R. B. Spires, M. D., DeFuniak Springs	..rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	B. W. Dalton, M. D., Vernon	R. H. Segrest, M. D., Bonifay		*Santa Rosa*	8	100%
	Jackson	D. A. McKinnon, M. D., Marianna	R. N. Joyner, M. D., Marianna	2nd Tuesday 7:30 P. M.	A-2-'39 N. A. Baltzell, M. D., Marianna	16	13
	Leon-Gadsden-Liberty-Wakulla-Jefferson	W. D. Rogers, M. D., Chattahoochee	B. A. Wilkinson,, M. D., Telephone Bldg., Tallahassee	Quarterly 3:00 P. M.	*Calhoun-Franklin-Gulf*	38	32
North Central District (B) Gainesville, October 27, 1938	Columbia	William S. Nichols, M. D., Lake City	Harry S. Howell, M. D., Blanch Hotel Annex, Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M. D., Lake City	18	15
	Madison	E. Long, M. D., Madison	Geo. O. Davis, M. D., Madison		*Baker-Dixie-Hamilton-Lafayette-Suwannee*	4	3
	Taylor	Ralph J. Greene, M D.. Perry	W. J. Baker, M. D., Foley	Last Friday 8:00 P. M.		8	6
	Alachua	T. A. Snow, M. D., 103 E. University Ave., Gainesville	H. M. Merchant, M. D., 124 E. University Ave., Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M. D., McIntosh	25	18
	Marion	Carney W. Mimms, M. D., Commercial Bank Bldg. Ocala	R. C. Cumming, M. D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P. M.		22	21
	Pasco-Hernando-Citrus	Samuel C. Harvard, M. D., Brooksville	G. R. Creekmore, M. D., Brooksville	2nd Thursday 7:00 P. M.		14	12
	Sumter	Clyde L. Carter, M.D., Wildwood	W. E. Mitchell, M. D., Bushnell	2nd Tuesday	*Bradford-Gilchrist-Levy-Union*	5	100%
N. E. District (C) Ponte Vedra Sept. 15, 1938	Duval	J. Lunsford Boone, M. D., 500 Professional Bldg., Jacksonville	George W. Croft, M. D., 713 Greenleaf Bldg., Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M. D., Jacksonville	160	137
	St. Johns	John J. Spencer, M.D., 32 Saragossa St., St. Augustine	Vernon A. Lockwood East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	*Clay-Nassau*	10	100%
	Putnam	Z. Brantley, M.D., Grandin	Allen P. Gurganious, M.D., Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7 00 P. M.	C-6-'40 George M. Green, M. D., Daytona Beach	10	8
	Volusia	Hugh West, M. D., DeLand	R. L. Miller, M. D., 258½ S. Beach St., Daytona Beach	2nd Tuesday 7:30 P. M.	*Flagler*	39	34
Southwest District (D) Bradenton, September 29, 1938	Hillsborough	Joseph W. Taylor, M. D., 706 Franklin St.. Tampa	James S. Grable, M. D., 811 Citizens Bank Bldg., Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M. D., Plant City	107	90
	Manatee	John F. Mason, M. D., Bradenton	M. M. Harrison, M. D., Bradenton	3rd Tuesday 7:00 P. M.		13	100%
	Pinellas	J. A. Strickland, M. D., 712 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D., 1005 Equitable Bldg., St. Petersburg	1st and 3rd Fridays 6:30 P. M.		89	88
	Sarasota	O. H. Cribbins, M. D., 224 Commercial Court, Sarasota	J. E. Harris, M. D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P. M.		15	12
	DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring	Howard V. Weems, M.D., Sebring	2nd Tuesday 8:00 P. M.	D-8-'40 Herman Watson, M. D., Lakeland	18	16
	Lee	H. Quillian Jones, M. D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M. D., 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P. M.		13	11
	Polk	W. W. Shafer, M. D., Haines City	J. R. Boulware, Jr., M. D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	*Charlotte-Collier-Glades-Hendry*	62	48
South Central District (E) Leesburg, Nov. 10, 1938	Brevard	G. E. Christie, M.D., Titusville	L. K. Hicks, M.D., Melbourne	3rd Tuesday	E-9-'38 W. C. Page, M D., Cocoa	12	100%
	Lake	Harry T. Fenn, M. D.., Mount Dora	W. L. Ashton, M. D., Umatilla	1st Thursday 12:30 P. M.		16	15
	Orange	H. A. Day, M.D., 209 Exchange Bldg., Orlando	Hewlit Johnston, M. D., Box 2002 Orlando	3rd Wednesday 8:30 P. M.		72	100%
	Seminole	J. N. Tolar. M. D., Sanford	Douglas G. Scott, M. D., Box 489 Sanford	2nd Monday 7:00 P. M.	*Osceola*	13	100%
	St. Lucie-Okeechobee-Indian River-Martin	R. C. Boothe, M.D., Ft. Pierce	Adrian M. Sample, M.D., Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M. D., Ft. Pierce	14	100%
S. E. District (F) Ft. Lauderdale Oct. 13, 1938	Broward	A. B. Connor, M. D., Sweet Bldg., Ft. Lauderdale	Oliver C. Brown, M. D., 915 Sweet Bldg., Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M. D., West Palm Beach	31	100%
	Palm Beach	V. M. Johnson, M.D., Good Samaritan Hospital, W. Palm Beach	J. R. Sory, M.D., 616 Harvey Bldg., West Palm Beach	4th Monday 8:00 P. M.		56	53
	Dade	Arthur H. Weiland, M. D., 227 Aragon Ave., Coral Gables	Claude G. Mentzer, M. D., 808 Huntington Bldg., Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M. D., Miami Beach	282	258
	Monroe	Harry C. Galey, M. D., 532 Fleming St., Key West	W. R. Warren, M. D., 511 Eaton St., Key West	1st Sunday 9:00 P. M.		3	



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Jacksonville, Florida, June, 1938

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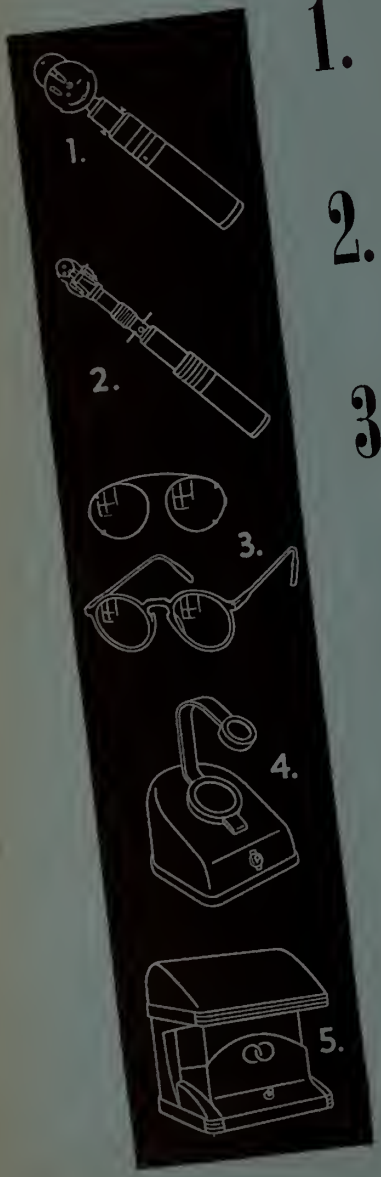
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Southern Medical Association, Oklahoma City, November 15-18, 1938.

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PREVENT Diphtheria by immunization with National Diphtheria Toxoid (Alum Precipitated). A single subcutaneous injection usually gives protection.

For Treatment

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BASIC OPERATIONS IN COMMERCIAL CANNING PROCEDURES

IV. SEALING THE TIN CONTAINER

BRIEFLY, the method of food preservation commonly known as "canning" involves subjecting food in a permanently sealed container to a heat process. The heat process destroys spoilage organisms present on the raw food material; the seal on the container prevents reinfection of the food by such organisms. It is, therefore, obvious that the sealing operation—"closing" or "double-seaming" as it is known in the industry—is one of the most important in the canning procedure.

The manufacture of tinplate and "sanitary" cans is described elsewhere (1).

The open cans are received at the cannery in paper cartons or in washed paper-lined box cars, together with the covers which are contained in fiber shipping tubes. Figure 1 shows a can and end ready for use.

In modern canning practice, the cans are first conveyed by automatic runways to can washers, and thence to the filling tables or fillers where the correct amount of properly prepared raw food is put into the cans. The covers or "ends" are placed in the automatic sealing or "closing" machine to which the open can containing the food is mechanically conveyed. In this machine the ends are "double-seamed" onto the can. This operation is portrayed by the accompanying cross-sectional pictures.

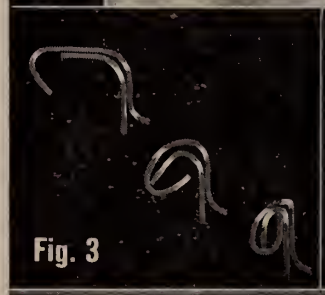
In Figure 2 is shown the relation of can to cover before the sealing operation is started; note the relative position of the "curl" on the cover and the "flange" on the can. In this curl, the can manufacturer has placed a gasket or "compound," usually containing rubber. Figure 3 is a series of photographs illustrating the sealing operation in which the curl and flange are first rolled into position and then the layers of metal flattened together to form the final "double-seam" in Figure 4. The rubber compound originally present on the cover supplies the binding material between the layers of metal necessary to insure a permanent or hermetic seal on the container. Figure 5 illustrates in cross-section a closed sanitary can as it comes to the consumer.

In the past twenty-five years great progress has been made in the development of tinplate, compounds and automatic sealing machines. Collectively, these developments enable present-day canners to impose a permanent seal on the cans containing their products more easily and rapidly than ever before in the history of canning.

(1) The Story of the Tin Can, American Can Company, New York, 1935











AMERICAN CAN COMPANY

230 Park Avenue, N. Y.

This is the thirty-seventh in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

Try PABLUM *On Your Vacation*

VACATIONS are too often a vacation from protective foods. For optimum benefits a vacation should furnish optimum nutrition as well as relaxation, yet actually this is the time when many persons go on a spree of refined carbohydrates. Pablum is a food that "goes good" on camping trips and at the same time supplies an abundance of calcium, phosphorus, iron, and vitamins B and G. It can be prepared in a minute, *without cooking*, as a breakfast dish or used as a flour to increase the mineral and vitamin values of staple recipes. Packed dry, Pablum is light to carry, requires no refrigeration. Here are some delicious, easy-to-fix Pablum dishes for vacation meals:



Pablum Breakfast Croquettes

Beat 3 eggs, season with salt, and add all the Pablum the eggs will hold (about 2 cupfuls). Form into flat cakes and fry in bacon fat or other fat until brown. Serve with syrup, honey or jelly.

Pablum Salmon Croquettes

Mix 1 cup salmon with 1 cup Pablum and combine with 3 beaten eggs. Season, shape into cakes, and fry until brown. Serve with ketchup.

Pablum Meat Patties

Mix 1 cup Pablum and 1½ cups meat (diced or ground ham, cooked beef or chicken), add 1 cup milk or water and a beaten egg. Season, form into patties, and fry in fat.

Pablum Marmalade Whip

Mix ⅔ cups Pablum, ¼ cup marmalade, and ¼ cup water. Fold in 4 egg whites beaten until stiff and add 3 tablespoons chopped nuts.

Pablum (Mead's Cereal thoroughly cooked) is a palatable cereal enriched with vitamin- and mineral-containing foods, consisting of wheatmeal (farina) oatmeal, cornmeal, wheat embryo, yeast, alfalfa leaf, beef bone, reduced iron, and sodium chloride. Samples and recipe booklet sent on request of physicians.

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1 oz. vol.	40 grams 120 cals.
1 oz. wt.	28 grams 90 cals.
1 teaspoon	15 cals.
1 tablespoon	60 cals.

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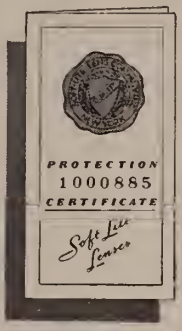
Infant feeding practice is primarily the concern of the physician, therefore, Karo for infant feeding is advertised to the Medical Profession exclusively.



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Cosmetics and Your Patient's Morale

☆



THE DOCTOR IS OF NECESSITY A STUDENT OF LIFE. Each new patient presents a new study, a new problem. Psychology plays an important role in the course of treatment he prescribes. With some patients he must be frank to a point of harshness, with others he must be gentle and coaxing. The nature of the illness and, more particularly, the nature of the patient determine his attitude. He knows from experience the value of bolstering his patient's morale. As a student of psychology he knows that few things are more depressing to a woman than the fear that she is losing her charm; that when she no longer cares how she looks the chances are she has lost touch with a vital interest in life. And because he appreciates the importance of a sensible interest in personal appearance he quite rightly encourages his patients to look their best at all times. FINE COSMETICS appeal to that interest. That is why they deserve to be recommended by doctors who are, after all, greatly concerned with their patient's morale.

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Laryngoscope, 1935, XLV, 149-154 ☐
N. Y. State Jour. Med., 1935, 35-No. 11, 590 ☐
Laryngoscope, 1937, XLVII, 58-60 ☐

SIGNED: _____ M. D.
(Please write name plainly)

ADDRESS _____

CITY _____ STATE _____

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President's Address*

EDWARD JELKS, M.D.
Jacksonville

Laymen, lay organizations and the public press today, perhaps as never before, are evincing interest in questions long active in the minds of medical men. Leading industrialists and a great number of politicians have been making studies and are volunteering solutions to vexing problems pertaining to the practice of medicine. In view of popular interest outside the profession, as well as vital interest within, it may be worthwhile to consider at this time the practice of medicine in general with the hope of clearing up some of the confusion of thought regarding these questions. Such consideration may be highly practical since those who are interested for various reasons are with increasing frequency questioning us as to what the medical profession is, what it means, and what it thinks about certain issues.

At the outset it may be wise to understand just what a profession is. The definition alone makes obvious the difference between the distribution of the services of a profession and the distribution of commodities that are controlled by commerce, trade and industry. To pass from one person to another material which can be weighed and measured is altogether a different matter from the rendering of a service by one individual to another. And that is what a profession is. Chapin and Queen aptly defined it in these words:

> "A profession involves personal service; second, this personal service is practical in the sense of being an art; third, there is an intellectual character to this service with considerable self direction and individual responsibility; fourth, the service is based on science and learning; fifth, it has a technic that is transmissible through an orderly and specialized educational discipline; sixth, there is usually payment for skilled service; seventh, members of the profession are a brotherhood; eighth, there is an increasingly altruistic motivation and devotion to the well being of those served and of the larger community; ninth, this sense of social responsibility is embodied in a code of ethics."[1]

A code of ethics, which may be considered the constitution for the brotherhood making up a profession, is one of the earliest records of medical literature. The Hippocratic oath, with which every informed man is familiar, is the outgrowth of ideas and relations through many generations prior to its writing. Coincident with the development of medicine, whatever the age or clime, always there has evolved a definitely known code of ethics. Out of the period of the Ming dynasty in China, free as it apparently was from the influence of Greek culture, there comes this code:

> "Do not make unnecessary delay, when called to see a patient, be he poor or rich. Give the required medicine whether you are paid or not. There will be some one to recompense you for your kindness. Do not see a girl, a widow, or a nun without the presence of another person. In the case of private disease, examine carefully, and never speak of it even to your wife. When you are called upon to see some person's mistress, treat her as one from a good family. Leave her as soon as your duty is done, and do not call again unless sent for. Do not use any substitutes for precious ingredients, such as pearl of amber. . . . Do not leave your office during office hours to join a picnic, excursion, or drinking parties. Attend to your patients in person. Write your prescriptions clearly and carefully."[2]

These ancient codes have the ring of modernity. Whether a code come out of classic Greece, medieval China or modern America, the import is much the same for the ethical

*Delivered before the Sixty-fifth Annual Meeting of the Florida Medical Association, held in Miami, May 9, 10 and 11, 1938.

ideal behind the practice of medicine remains surprisingly constant.

The origin of these codes lies in the recognition by the profession, first, of a very real relationship between the one endeavoring to heal and the one to be healed, and, second, of quite as important a relationship between the physician and the community. Today the physician is a familiar figure in positions of leadership in those activities that have to do with the normal physical and social betterment of the community, as expressed through public health agencies, boards of charity, churches, schools and like institutions. Not only in our day but since recorded time medical men have participated in the numerous efforts and movements for the benefit of the community in general. In this particular the physicians of Florida have made and are making a record of which they may well be proud. It is inspiring to us all that we, the practitioners of Florida, have such illustrious predecessors as Dr. Henry Perrine, who introduced from the tropics more than seventy varieties of plants that have made the life of our people fuller; Dr. John Gorrie, our state's representative in the national Hall of Fame, who, in an effort to discover the cause of fever, made practical the first machine for manufacturing artificial ice, thereby ushering in our present era of air conditioning; Dr. Andrew Turnbull, a pioneer of the early days, who founded a colony on the East Coast; Dr. A. S. Baldwin and many others, who were active in securing appropriations from the Congress for harbors; Dr. J. Y. Porter, who for more than thirty years was the State Health Officer; and Dr. William C. Wells, who at St. Augustine published the first newspaper in the state, and who later in England explained the formation of dew and also the relation between rheumatic fever and organic heart disease. That the physicians of Florida are public spirited men their history attests.

In view of our record, both past and present, it will be disappointing, when it comes to the question of interest in the general health of the people, and indeed not understandable if we today ignore the problem of medical care for everybody. To consider it, however, does not mean that we consent without reservation to a recent statement that has come almost to be a slogan, namely, "The health of the people is the concern of government." Our past has shown that we regard the health of the people as the concern of agencies that have the power to render the needed help, but by this acknowledgment we do not mean that these agencies, governmental or otherwise, should have the direction and decision as to the kind of aid given. That prerogative lies with those who are to give the aid, that is, the physicians, for they are the only ones who can properly render this service.

Unity of interest in the public good is within itself enough to create a brotherhood, were such an association of kindred interests not already the outgrowth of other influences. To the laity it is hardly understandable that men whom it considers to be competitors, one with the other, can maintain the fraternal relations existing between physicians. It is striking how puzzled the layman becomes when a consultant will not consider taking a patient away from the brother physician who has called him in, even though the handling of the case would mean financial remuneration and perhaps wider professional recognition. The difference between good sportsmanship and competition does not seem to be clear in the minds of laymen. This attitude is not difficult to explain when one considers that the layman is not informed as to the differences in opportunities that may have come to the two physicians, nor can he appreciate the difference in problems confronting them in their varying types of practice. It may be a simple thing for one physician to develop a practice that tries his best professional talent and at the same time renders a very lucrative remuneration, whereas another physician with equal or greater talent, and with greater sincerity and industry, may meet with little evident success. In fact, even we of the profession do not ourselves know one another's burdens and problems. The realization of this limited understanding should engender among us a kindlier spirit of toleration. Even though the weaknesses of human nature are responsible for many unkindnesses among physicians, it is my belief that the percentage of their occurrence is less than in other groups.

A sure way to promote the fraternal spirit of our profession is through the organization

of its members. To be with one another at medical meetings, to serve together on committees, to attend the presentation of scientific programs where papers are presented by friends, to take part in the varied activities of organized medicine, all such participation is bound to give a growing knowledge of one another and a fairer appreciation of our fellowmen in the brotherhood of physicians.

Compensation for services rendered by this brotherhood has varied widely through the ages. From the Code of Hammurabi we learn that a surgeon's fee in Babylonia varied according to the social standing of his patients, as was also true in Persia and Egypt forty centuries ago. The honorarium of the early Greek physician, purely an honorary gift, had by the time of Hippocrates become a professional fee, which likewise came to be regulated according to the wealth of the patient. This procedure has not been abrogated because no better method has as yet been devised.

Although Aristophanes reminds us that at times a physician had to make a call for no fee, quite as today, the maximum fee among the Greeks for a night call was one hundred dollars and the minimum about twenty cents. Many Roman families paid their physician an annual salary, and court practice was highly lucrative, but the ordinary practitioner received about thirty cents for a visit, an amount equal to more than three dollars now. The fee of the English physician of the thirteenth century was fifteen cents for a day call and about twice as much for a night visit, a fee better than the average today for fifteen cents was two or three times as much as the laborer's daily wage and would purchase three fat geese or two pairs of shoes. In Colonial days in America, when a turkey cost thirty cents, a goose twenty, and eggs were six cents a dozen, the physician fared better than many of us do at present. The first fee for consultation was five dollars, medicine included, and all subsequent fees two dollars without medicine; the charge for office visits ranged from fifty cents to one dollar with all medicine extra and charged for at a price good even for today.

Despite the Jewish injunction in the Talmud to "look to your pay, O Physician, for that for which nothing is paid, the same never cures," the question of fees is, nevertheless, ever a difficult one. In the light of the ability of the patient to pay, schedules through the centuries record an attempt, ages old, to fix compensation on the basis of help given regardless of who renders the service. Financial bidding for patients is contrary to the ethics and destructive to the morale of the profession; it therefore has no place in the brotherhood of physicians.

To qualify for admission into this brotherhood, the candidate has from time immemorial undergone a definite educational discipline. From earliest times almost up to the present day the system of apprenticeship was in operation, and only within our time in this country have the medical schools been raised to practically one standard. As a result, physicians graduating now are better trained as a group than they have even been, but such efficient training has had the deleterious effect of encouraging young physicians to locate in communities that are medical centers rather than to spend their lives in the more isolated communities where each medical man must be a self-sustaining unit. Also, the proper education is so expensive that it is difficult for a man to go to the less thickly populated sections and realize more than a very inadequate return for the money invested in his training.

Obviously, the education of a physician does not cease when he leaves medical school. It continues as long as he lives, not only through what he learns from taking care of sick people but also through the activities of medical societies, through medical literature and postgraduate work. Florida is fortunate to be one of the few states that has successfully maintained for as long as six years a postgraduate course each summer for the members of its medical profession. This accomplishment is a credit to organized medicine and a great help to the physicians of the state. Interest in this course has steadily increased as evidenced by an enrollment of 135 last June. The physicians of the state have also shown their conviction of the necessity for continuing education by activity in the various general and special medical societies. There are 1243 members of the Florida Medical Association; in this group are those who hold 360 memberships in the special societies. In 1937, there appeared in periodicals other than The Journal of the Florida Medical Association 41

scientific papers written by members of this association.

The basis for this educational discipline is science and learning. Therein lies the great difference between the arts and the crafts. Although there are many points of similarity in the execution of a profession and a craft, the foundations upon which they rest differ widely, for medicine is based on the highest stratum of science. Throughout the ages medicine has been quick to recognize truths in scientific discoveries that could be utilized for the health of the people. Until quite recently the compound microscope was used in the arts almost exclusively by medical men. Hardly was Pasteur's work on micro-organisms under way before Lister, realizing its important bearing on the healing of wounds, instituted the practice of antisepsis. The first practical use of the roentgen ray was for the diagnosis and treatment of disease. The medical profession first adapted to practical use the radium discovered by Curie. As the science of psychology advances, the psychiatrist immediately uses its discoveries for the help of persons who are mentally sick. It has been a matter of only a very short time between scientific discovery and its utilization, whenever possible, in medical practice.

It may seem unfortunate that scientific knowledge can seldom be applied directly in a group manner to the care of the sick. The reason such application is not possible is because the individual variations in the condition of those in ill health are so innumerable and diversified that the specific patient requires for the solution of his trouble a highly individualized service. The one who renders it must have the freedom of self-direction. Obviously, this service carries with it a very heavy responsibility. The sick person cannot be considered merely as a number nor even as an individual with a certain disease. He is a product, not only of his present trouble, but of heredity and of the years of his past experience, all of which must be considered by the one who would help him recover. To limit the physician by rules and regulations would stifle the initiative that might solve a problem and perhaps save an individual, thereby opening up an avenue for the relief of millions in a similar difficulty.

Ephraim McDowell had been taught that the removal of a large ovarian cyst was impossible, but, when he was confronted with the responsibility of letting Mary Crawford die or trying the apparently impossible, his reason prompted him to exert his individual self-direction, with the consent of Mary Crawford, and he attempted the untried. A restriction of his initiative might have delayed the benefits of abdominal surgery for many years. Crawford Long and James Venable had no one to prevent their trying ether as an anesthetic. The country physician, Robert Koch, had the freedom of action and thought necessary for the development of the modern principles of bacteriology. Pasteur was not thwarted either by governmental or lay agencies. Our present would be much the poorer, had it not been for the unrestricted initiative of those who have gone before us in medicine, not only those who are nationally and internationally recognized but also the general practitioner over the land, whose work has been to guard and maintain the health of the people.

These physicians have practiced the art of treating sick persons. Science alone cannot give to the person who is ill what he needs to restore him to health. The way in which the service is rendered is frequently just as important as the remedial agent itself. Personal relations are not scientific. They are matters of conduct and, therefore, in execution are an art. Science cannot make a well rounded life. In fact, science is but the means of securing the best things in life through art. One of these very best things is the restoration of the body to health and the preservation of the well body. This personal service, then, is something that cannot be measured nor weighed nor estimated except through the recognizable results. In order to achieve a happy outcome there must be between him who gives and him who receives a private relationship, one which at times may necessarily be intimate. The laws of our country recognize the privacy of this relationship, making that which transpires between the physician and the patient a secret matter, not to be made known except with the consent of the patient. Indeed, so intangible is the physician's service that even the records which are necessarily

made for diagnostic purposes are not considered the property of the patient. The courts have ruled that what the patient receives is the service and not the record, although he may secure a copy of the record if he so desires.

One of the interesting and impressive facts in medical history is that in every period in which there have been activities that might lead medicine away from this personal relationship, the proper leader has arisen to express the thoughts and principles of the physicians as a whole. Weaving its way through the centuries from antiquity to the present time, a golden thread marks the continuous progress of the art of the practice of medicine. The writings of Hippocrates were lessons to the physicians of ancient Greece teaching them that the philosophy of Socrates, the theories of the scientists, the modern thought of that day, valuable as these were, could not take the place of individual study of the sick man. Following the Dark Ages in Europe, medical thought for centuries centered around the idea that disease was the result of the imbalance of vague body fluids. It was Rhazes of Bagdad who reawakened physicians to the age-old necessity of studying and treating the individual. After the Renaissance, when a new world was opening up, thought everywhere broadened into wider fields of philosophy and new avenues of interest; men's minds came to dwell on the universe as revealed through the telescope; Harvey's discovery of the circulation of the blood brought about the birth of modern physiology. During this period when theories were rife indeed, that plain, wise Englishman of infinite common sense, Thomas Sydenham, spent his life urging upon his fellow practitioners that there was no way to practice their profession other than by individual contacts between the physician and the patient.

When the glorious scientific discoveries of the nineteenth century were creating a modern scientific medicine, when the bacterial cause of disease was being established and a pathology based on the changes in the cell was being founded, when the mystery of the chemical processes within the body was being solved and the understanding of living pathology was becoming more universal, one of the most scholarly, highly trained and scientific men of his time emphasized the principle of clinical medicine. Sir William Osler will, for this reason, be recognized for generations to come as the great physician of his day. He exemplified the truth that science alone is not a practitioner, but that the truly successful physician is he who uses scientific knowledge to practice the art of medicine through the proper personal relationship between him and the sick person.

During the year now closing, as I have gone through the state conferring with members of the Florida Medical Association, these thoughts about our profession have run again and again through my mind. The outstanding feature that I have observed is a general feeling of brotherhood among the best educated professional group in Florida. These men and women of our Association are interested in the physically and mentally sick and their problems especially, but they are widely interested as well in the affairs of their respective communities and their state. They comprise a group bound together by a spirit of fraternity in an organization, the Florida Medical Association, which is a part of the great body of organized medicine. The idea comes that it is for no haphazard reason, no scheming plan, that this great body of American physicians is in many respects the most remarkable organization in the world today. It is the normal outgrowth of a self-directed brotherhood with individual responsibility, rendering personal service through education and discipline based on science and knowledge, an organization characterized by an ethical code of highest standard and an altruistic devotion to the welfare of the community. Is it worth preserving? Should it be defended against the attacks to limit its benefits, even though these attacks be made in all sincerity and honesty? Let us not sit idly by, but with a keen interest and a clear eye see the situation and persevere to preserve those good things that have evolved through the many centuries that the art of medicine has been practiced.

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2. Charr, R.; Ancient Chinese Medicine. Annals of Medical History, New Series, Vol. 8, No. 3, p. 245.

2033 Riverside Ave.

PROCEEDINGS

of the

SIXTY-FIFTH ANNUAL MEETING

of the

FLORIDA MEDICAL ASSOCIATION, Inc.

HELD AT MIAMI, FLORIDA

MAY 9, 10 and 11, 1938

FIRST MEETING OF HOUSE OF DELEGATES

The House of Delegates convened at 9:00 a. m., Monday, May 9, 1938, in the Bahama Room of the Columbus Hotel, Miami, Florida, with Dr. Edward Jelks, president, presiding.

On roll call the following delegates were seated:

DELEGATES

ALACHUA COUNTY MEDICAL SOCIETY:
J. L. Summerlin
BAY COUNTY MEDICAL SOCIETY:
D. M. Adams
BREVARD COUNTY MEDICAL SOCIETY:
T. C. Kenaston
BROWARD COUNTY MEDICAL SOCIETY:
G. S. McClellan
L. F. Robinson
COLUMBIA COUNTY MEDICAL SOCIETY:
H. S. Howell
DADE COUNTY MEDICAL SOCIETY:
J. S. Stewart
M. J. Flipse
Walter Jones
M. M. Coplan
Homer Pearson
Scheffel Wright
Duncan Owens
Herman Boughton
R. N. Burch
Marion Salley
H. A. Walker
F. R. Morrow
C. G. Mentzer
DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY:
L. W. Martin
DUVAL COUNTY MEDICAL SOCIETY:
J. Lunsford Boone
R. B. McIver
L. Y. Dyrenforth
F. J. Waas
H. B. McEuen
W. McL. Shaw
G. H. Ira
ESCAMBIA COUNTY MEDICAL SOCIETY:
J. M. Hoffman
J. S. Turberville
HILLSBOROUGH COUNTY MEDICAL SOCIETY:
W. M. Rowlett
W. C. Blake
H. Mason Smith
J. R. Boling
JACKSON COUNTY MEDICAL SOCIETY:
N. A. Baltzell
LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY:
J. H. Pound
B. A. Wilkinson
MANATEE COUNTY MEDICAL SOCIETY:
L. W. Blake
MARION COUNTY MEDICAL SOCIETY:
E. G. Peek
ORANGE COUNTY MEDICAL SOCIETY:
Horace A. Day
J. R. Chappell
Hewitt Johnston
PALM BEACH COUNTY MEDICAL SOCIETY:
F. K. Herpel
V. M. Johnson
George M. Dawson
PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY:
S. C. Harvard
PINELLAS COUNTY MEDICAL SOCIETY:
W. M. Davis
A. J. Wood
W. C. McConnell
O. O. Feaster
POLK COUNTY MEDICAL SOCIETY:
Geo. Carefoot
J. Boulware
PUTNAM COUNTY MEDICAL SOCIETY:
A. P. Gurganious
ST. JOHNS COUNTY MEDICAL SOCIETY:
H. E. White
ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY:
H. D. Clark
SARASOTA COUNTY MEDICAL SOCIETY:
A. L. Matthews
SEMINOLE COUNTY MEDICAL SOCIETY:
A. W. Knox
VOLUSIA COUNTY MEDICAL SOCIETY:
J. R. Wells
L. von Meysenbug

On motion duly seconded and carried the minutes of the last meeting were adopted as published in the April, 1937, issue of the Florida Medical Journal.

Motion by Doctor Rowlett that the Association adopt a resolution expressing sympathy to Doctor Weiland in the loss of his brother.

Motion seconded and carried.

President Jelks called for the nomination of one delegate and one alternate to the House of Delegates of the American Medical Association for two-year terms.

Dr. Herbert L. Bryans was nominated by Dr. J. M. Hoffman for reappointment as Delegate to the A. M. A. Motion seconded and unanimously carried. Elected for two years.

Dr. J. S. Turberville was nominated by Doctor Herpel as alternate delegate to the A. M. A. Motion seconded.

Dr. Herbert E. White was nominated by Doctor Owens as alternate delegate to the A. M. A. Motion seconded.

Nomination withdrawn by Doctor Turberville as he will be unable to serve.

Dr. Herbert E. White of St. Augustine elected alternate delegate to the A. M. A. by unanimous vote, for two years.

President Jelks appointed Dr. W. M. Rowlett and Dr. Joseph Stewart to draw up a resolution on the death of Doctor Weiland's brother for adoption at the next meeting of the House of Delegates.

The following resolution was read by Dr. M. J. Flipse of Miami.

Whereas, the Florida Medical Association has heretofore by resolution shown its interest in the care and control of tuberculosis in the State of Florida, and

Whereas, the State of Florida has constructed and put in operation the State Tuberculosis Sanatorium at Orlando during this last year, and

Whereas, the Tuberculosis and Health Committee of the Florida State Medical Association has observed with satisfaction and approval the harmonious and efficient conduct of this institution under the direction of Dr. R. D. Thompson, the Medical Director and Superintendent, and under the direction of the State Tuberculosis Board appointed by the Governor, therefore be it

RESOLVED, that the Florida Medical Association in meeting assembled do hereby compliment the Governor and his Cabinet; the State Tuberculosis Board; the Superintendent, Dr. R. D. Thompson, for their efficient work, and that a copy of this resolution be sent to the Governor, the State Tuberculosis Board and Dr. R. D. Thompson.

On motion duly seconded and carried the above resolution was unanimously adopted.

The following resolution was read by Dr. Hewitt Johnston of Orlando:

Whereas, there is a wave of propaganda both within and without the medical profession sweeping this country to socialize the practice of medicine; and

Whereas, up until the present time no plan has been brought forth either by the proponents or opponents of socialized medicine to correct the ills and injustices of the practice of medicine; and

Whereas, the people are looking toward the American Medical Association to take a constructive stand in this matter; therefore be it

RESOLVED, that the Speaker of the House of Delegates of the American Medical Association appoint a committee of seven, one member to come from the Board of Trustees, one from the House of Delegates, one from the so-called "Committee of 430" and four from at large from the profession who hold no official position in the American Medical Association; and be it further

RESOLVED, that this said committee meet with the Board of Trustees and officers of the American Medical Association and others and stay in session until constructive plans are formulated, if possible, and the said report to be filed with the House of Delegates for consideration at the next annual meeting or at special session if necessary; and furthermore be it

RESOLVED, that the Board of Trustees set aside a sum of money to defray all expenses of the investigation and the time of the members of all committees.

On motion duly seconded and carried the above resolution was unanimously adopted.

Recommendations of the Executive Committee were read by the Chairman, Doctor Osincup:

(*See second meeting for resolution on registration fee.*)

Recommendation on registration fee was held over until the second meeting of the House of Delegates the following day.

"After studying applications from County Societies, your Committee recommends the acceptance of the invitation from the Volusia County Medical Society to make Daytona Beach the meeting place of the Sixty-sixth Annual Convention of the Association, in 1939."

On motion duly seconded and unanimously carried Daytona Beach was selected as the meeting place for the 1939 convention.

Recommendation on registration fee reread for consideration.

Amendment by Dr. M. M. Coplan of Miami, to the effect that this recommendation apply except where new members are coming into the Association who have never practiced medicine before.

Doctor Rowlett:

"I would like to call your attention to the fact that the Florida Medical Association and its County Societies, have by far the smallest dues of any of the practitioners of the healing art in the State of Florida. I understand that the Dental Association in addition to its regular dues has an emergency assessment of about fifteen or twenty dollars, and some other healing arts in addition to their regular dues pay into their societies about fifty dollars. I just want to call that to your attention.

Dr. F. K. Herpel:

"I have been treasurer of the Palm Beach County Society for the past seven years and I have found that each year during that time it has become increasingly easy to collect dues. Seven years ago it was extremely difficult to collect dues. I find that as the activities of the Florida Medical Association increase, as the Association becomes a better organization, with better contact between state officers, better meetings, better general

fellowship, it has become increasingly easy to collect dues. I would like to second the remarks of Doctor Rowlett. Other associations pay four, five or six times as much, cheerfully, to maintain their membership in their national societies. I am in favor of the original recommendation of the committee."

Doctor Coplan:

"In order to make the amendment more specific, make this increase or assessment applicable to all applicants other than those who have completed their original hospital internship not more than eighteeen months prior to making the application."

Dr. Hewitt Johnston:

"Opposed, because most of the interns are paid for their services, and should be able to save that much. Think no one should be exempt."

This recommendation of the Executive Committee referred to second meeting of House of Delegates.

The next order of business was the reading of Committee reports.

The following report of the Council was read by the Chairman, Dr. W. McL. Shaw:

REPORT OF COUNCIL

At the Pre-convention Meeting, held in Tampa, January 16, 1938, the district councilors' reports were received. These were published in full in the February number of the Association's Journal. As chairman of the Council, I will briefly outline some of the major activities of the Council during the past year.

The first official meeting of the Council was held in Orlando the fourth week in June at the Orange Court Hotel. Eight of the twelve councilors were present and plans were approved for holding an annual meeting in each of the six medical districts. The first annual medical district meeting was held in Apalachicola, July 15. The last of the series was held November 11, at Plant City. A complete program and write-up of each meeting appeared in the Journal, so that each member has had an opportunity to judge as to the effectiveness of this major project of the Council. Your Managing Director, Stewart Thompson, visited the councilors and officers of the component societies in each district to assist in arranging the programs, facilities for holding the meeting, etc. He also took care of the registration of members and guests at the meetings. In addition to announcing each meeting in the Journal, a printed program was mailed to every member in the district prior to the meeting. The meetings were also announced in the various newspapers throughout the district.

The total registration for the six medical district meetings was 450. Of this number 287 were members living in the districts, 36 were members of the Association as visitors, not living in the districts, and 127 were doctors and guests who attended but were not members of organized medicine. One hundred sixty-two members of organized medicine attended one or more of the medical district meetings, who were not able to attend the Association's annual meeting in St. Petersburg. It is interesting to note, in checking over the registration, that half of the members who attended the district meetings were not able to attend the annual meeting in St. Petersburg. The value of the annual medical district meetings is, therefore, emphasized in that they extend an opportunity for a large number of our members who find it impossible to attend the Association's annual meeting, to get together, meet the officers of the Association and hear scientific papers. Every member of the Association has had an opportunity during the year, to attend an annual meeting with a maximum travel of one hundred miles.

The second major activity of the councilors was to stimulate interest in getting members for organized medicine. A typewritten list of doctors licensed in the state was furnished to each councilor and to the secretary of each component society. This list was prepared according to councilor districts. I am glad to report that your councilors, through personal investigation, studied and reported on the individual names of doctors thus listed, and have furnished to the component societies and State Association officers, some very valuable information on doctors who are eligible for membership. A number of doctors are now bona fide members of organized medicine through the efforts put forth along this line. The constructive efforts already put forth will undoubtedly bring definite results in the future. As an example, through the efforts of one councilor, five doctors became members of the State Association in February. It is our

opinion that the councilors, as a whole, have been more active during the past year than in any previous year. The work is most constructive in that it is statewide and will be the means of strengthening organized medicine as a whole.

The dates and meeting places for 1938 for the annual medical district meetings were scheduled at the last meeting of the Council, which was held in Tampa, January 16. This schedule has been published in the Journal and will be found on the inside back cover from month to month.

I wish to commend most heartily each of the twelve councilors who have cooperated wholeheartedly during the year and, on behalf of the councilors, I wish to express deep appreciation to the officers of the Association who attended the six annual medical district meetings and made such valuable contributions to their success. Particularly I wish to to commend the valued assistance of our Managing Director, Dr. Stewart Thompson. Without his counsel and cooperation much of this work could not have been accomplished.

Respectfully submitted,

W. McL. Shaw, Chairman.

Dr. Jelks:

"I want to take this occasion to thank the Council this year for the fine work they have done for the Florida Medical Association. That is true of every one else who has worked in the Association, but this being a new operation it was a little uncertain as to how it might work out. To me it appears a very excellent way to help improve the efficiency of the Florida Medical Association."

The following report of the Committee on Legislation and Public Policy was read by Dr. J. C. Davis, Chaiman:

REPORT OF THE COMMITTEE ON LEGISLATION AND PUBLIC POLICY

One year ago the State Legislature was in session. I, as chairman of your Legislative committee, had been, was, and continued to be throughout its session, as busy as the proverbial bee in a tar bucket.

Unless one of you has faced the strain, the worries, the trials and hazards of working with and through a legislative session, I cannot possibly convey to you the manifold tasks, and troubles to be encountered and dealt with.

Prior to the opening of the session a vast amount of work had been done by us and by local members of the Association in their various towns and districts in acquainting all concerned with the legislation we were sponsoring, and what is more, just *why* this legislation was necessary to the public health, and why we, as the trustees of the public health, considered it eminently worthwhile to exert time and trouble to get this proposed legislation enacted into law.

We faced the opening of the session in an optimistic mood. We knew from past experiences what, in general, to expect from then onward. We knew that subversive influences would be working day and night against us. We felt, however, that the majority of the members of the legislature were favorable to these new laws, and that if we could once get them up for a final vote we would encounter no serious difficulty.

I wish to say now that, in my opinion and in the opinion of those who worked with me, we have found no reason to discard that view. Every time one of these proposed measures came up for a final vote, it was passed with a large majority. I believe that in the next session of the legislature if we can get these bills up for final passage, that they will be enacted into law without serious difficulty.

Just as it is impossible to tell what, if anything, a proposed specific will cure, until it has been tried out under particular conditions, it is equally impossible to accurately foretell just exactly what changes will be found necessary in any proposed legislation, until it has been subjected to the cross-fire of legislative criticism. Our proposed laws had been carefully drawn and checked, but shortly before or just after their introduction, it was found necessary to make some minor changes here and there in practically every bill. In general, however, the general idea was followed implicitly and the effect was intended to be the same, that is, a better public health for the State and its people.

Just as it is usually more difficult to cure a sick man than it is to keep a healthy man well, it is more difficult to get legislation enacted than it is to defeat undesirable legislation. Therefore, since we were shouldering the burden of trying to get some positive action, we had a more difficult task than did those whose

interest caused them to seek the defeat of the bills, as their only necessary action was negative in character.

You are already familiar in general with the legislation under discussion. One was a bill to provide for a better and more specific definition of the practice of medicine; one was to provide a lien for medical, nursing and hospital services; one was to require practitioners of the different healing arts to properly designate just what branch of healing they were practicing, so that the public would not be misinformed; and one was the Basic Science law.

To show you that we are making some headway and that our work was not entirely unsuccessful we report the enactment into positive law of one of these bills, that is the designation act. To get even this bill passed required a great amount of unrelenting effort as we found opposition every step of the way. This opposition was not found on the floor of the House and Senate but was found in a steady and powerful effort of those opposing the bills to keep them from ever coming before either body for a final vote. The medical practice act and the lien law were each passed by the Senate with only 3 or 4 dissenting votes. The Basic Science law against which the most strenuous and concerted effort was made by its foes, never was voted on in final passage by either house.

Let me say a few words for those whose efforts in behalf of this legislation were outstanding. Dr. Dame, the chairman of the Senate Public Health committee, lost no time in getting the bills recommended favorably by his committee. His careful and conscientious work was a deciding factor in effecting the passage by the Senate of the two bills just mentioned.

Senators Sweger and Touchton deserve great credit in cooperating with Doctor Dame.

Doctor Eide, chairman of the House Public Health Committee, had a larger committee, and it was in this committee that we found much of our most serious opposition. After a long and concerted effort by all those interested in the passage of these bills, including many individual members of our profession, this committee finally approved by a majority vote, all our bills, to which had been added by the committee some minor amendments. The opposition, however, had delayed us too long, and though every reasonable effort was made to get these bills up for final passage in the house we were unable to do so. The tremendous pressure that exists toward the close of every legislative session was also a material aid to our opponents in blocking our efforts to get these bills up during the final days of the session.

Dan Chappell, at the instance and request of the Dade County Society, was present in Tallahassee and worked diligently in our behalf for most of the session. Mr. Chappell is a former member of the House of Representatives, an experienced legislator, and a former candidate for Governor. He is due our sincere regard and thanks for the vast amount of time and effort he expended in our behalf. This was done, he says, because it was his desire to lend his support to the Medical Profession in Florida, and especially to the Dade County Medical Society, free of charge. He worked untiringly and we did not fail through lack of competent and experienced assistance.

Dr. Stewart G. Thompson, our Managing Director, was of invaluable assistance. He worked diligently and intelligently in our behalf, and was always available when and where needed. It would be almost impossible to conceive of conducting another campaign in favor of these bills without him.

Many members of the legislature were favorably inclined to this legislation, and toward them, we feel grateful. There were a few, however, who were outstanding in taking an active part on behalf of these bills. Among these, in the House of Representatives, we list:

Martin, of Hillsborough County
Dekle, of Hillsborough County
Sinclair, of Polk County
Bryant, of Alachua County
Collins, of Leon County
Doctor Eide, of Highlands County
Fahs, of Lake County
Leedy, of Orange County
Papy, of Monroe County
Slappey and Davis, of Gadsden County

We are not listing our special friends in the Senate, as practically that entire body was favorable to our legislation, or at least not opposed to it.

Your chairman has been subjected to some unwarranted criticism because a letter written by him as a confidential communication to certain members of our Association regarding the legislation and some of the members of the legislature, fell into the hands of those most actively engaged in opposing us. This letter was based on what I then believed to be correct information. As it later turned out some of it was incorrect. Be that as it may, no one regrets more than I do that this unfavorable publicity was given us. As far as enacting our legislation was concerned, however, I do not believe it caused us any ultimate harm whatsoever. In fact I think it reacted somewhat in our favor at a later date, and when the matter had been thoroughly explained we found no evidence of further ill-feeling. It was, of course, evident to all why this publicity was started, and the unfairness of its being used in an effort to further selfish aims in opposition to us, did, in my opinion, later react against those publicising it.

As an aid in securing the passage of these bills in the future I make the following recommendations:

1st. Redouble your efforts locally to gain the *active* support of your representative and senator. This cannot be emphasized too much or too often or too forcibly. This alone will not be sufficient, but without it we can hope for no success at all.

2nd. Make every effort to get an *experienced legislator*, who will *actively* support these proposed laws, as a chairman of the Public Health Committee in each House. Having a doctor as a chairman works as a handicap for it causes the uninformed to look upon him as the personification of the profession, and any personal enmity or dislike they have for him is thus visited upon the entire profession and the laws it sponsors. This is said in full recognition of the efforts of doctors in the past who have been chairmen of these committees and does not in the least detract from the hard work they did nor the results they accomplished. I believe they will be the first to agree with me that the foregoing statements are true. The chairman must be experienced, because so much of the most difficult part of the program is met with in committees. The uninitiated, no matter how industrious, how well meaning and how sincere, cannot hope to compete on even terms with an equally sincere, well meaning, industrious and experienced man.

3rd. Make an effort to find out just how your representative and senator stood last term with regard to this legislation. Find out what his attitude will be at the next session, and with that in view use your local political strength where it will best be served.

4th. Make every effort to have appointed on each Public Health Committee, the men who are actively interested in behalf of these vital laws. If they are not actively interested try to get the men who at least will not adopt an attitude of vigorous opposition to the legislation merely because the profession is sponsoring it, and some other profession is opposing it.

Respectfully submitted,
J. C. Davis, Chairman;
Horace A. Day
Henry C. Dozier,
Gerry R. Holden,
Walter C. Jones
Whitman C. McConnell

The report of the Committee on Medical Education and Hospitals was read by the Chairman, Dr. Leland F. Carlton, as follows:

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Your committee has, when called upon, endeavored to function to the best of its ability in matters which it considers for the betterment of the Medical Profession of the State of Florida at large. It was our good fortune to attend the opening of the Broward County Hospital at Melbourne, which institution should be a credit to the city of Melbourne and the surrounding territory.

At the Pre-convention Meeting of the Florida Medical Association held in Tampa, the members present went on record as favoring a survey of hospitals in Florida to determine available hospital accommodation for the indigent, this survey to be made by the Works Progress Administration and sponsored by the State Board of Health in conjunction with your committee on Medical Education and Hospitals. A request was made that the results of the survey be sent to our representatives and senators in Washington, that they might have full report of the same. Your

committee offered its services to cooperate with the Works Progress Administration in this work, but has not yet been called upon to do so.

Your committee on Medical Education and Hospitals with the officers of the Association, members of the Executive Committee, the Committee on Medical Economics, and the representatives of the Florida Radiological society on November 28, met in Jacksonville with Dr. R. G. Leland, director of the Bureau of Economics of the American Medical Association, to discuss hospital insurance.

Since the beginning of the medical era, physicians have been capable of, and have been prepared to look after the care of the sick, better than any other professional group or hospitals. The traditional function of hospitals is not to enter into the practice of medicine, but to furnish facilities which one does not have at home; that is to furnish board, lodging, and nursing care, and to leave the medical care solely in the hands of the Medical Profession. There has been a trend in the past two years for insurance companies and hospitals alike to attempt to enter the practice of medicine. We feel that the Medical Profession is opposed to any plan that will destroy the basic features of medical service, or will permit hospitals to enter the practice of medicine. For that reason your committee on Medical Education and Hospitals submits the following resolution to be acted upon by the Florida Medical Association.

(*See second meeting of the House of Delegates for text of resolution*).

Respectfully submitted,
LELAND F. CARLTON, Chairman
JOHN R. CHAPPELL,
JOHN N. MOORE,
WALTER C. PAYNE
ROBERT B. MCIVER,
PAUL B. WELCH.

Motion by Dr. W. M. Rowlett to adopt this report and all other reports read prior to this time today. Seconded.

Amendment of motion, that a copy of this last report be sent to each hospital in the State of Florida, with possibly certain excerpts from it.

Amendment accepted by Dr. Rowlett.

Doctor Flipse:

"I feel that there are certain parts of this report very specifically outlined and if a copy of this report finds itself in the hands of hospital authorities the question is going to arise as to what constitutes the practice of medicine. This has always been an embarrassing situation in dealing with hospitals that hire by the year a pathologist, a roentgenologist or physician engaged in clinical laboratory procedures. That has on previous occasions constituted a stumbling block. If we take this step it is going to be very embarrassing. Theoretically, I believe we are all in accord in regard to this matter, and now the question is the advisability of applying it. There is now some doubt and I think it should be specifically stated just what is meant if this report is going to be sent to the different hospitals. I therefore suggest that this committee specifically outline these few points in this recommendation in regard to these pathologists, anesthetists, clinical laboratory technicians, roentgenologists and all other matters which pertain to the practice of medicine in hospitals, before this report is submitted to the various hospitals throughout the state."

Dr. H. A. Day:

"Another fact which I think is rather important. In different parts of this state and other states the Boards or agencies of charity maintain hospitals in centralized areas to handle the work on their patients. These centralized hospitals are operated and run by the Board or members of charity organizations and not by doctors. They hire their medical superintendent and their business manager. All of the doctors work for them on a salary. They charge for the patient's hospitalization and medical fee and it all goes to the hospital except for the salaries paid out to the doctors. Where would you put them? What are we going to do in the Association with the doctors who hire themselves out to the hospitals? What penalty? Otherwise the recommendation is no good."

Doctor Jelks:

"This is a question we are all interested in. What is done at this meeting will probably be a rather important step."

Doctor Dyrenforth:

"I am particularly interested in what Doctor Flipse had to say because I am a pathol-

ogist. We are overlooking the fact and this resolution omitted it, that the intent of this organization is to keep hospitals and other lay bodies from interfering with the so-called income of the profession. However, we are making too many inroads on the immediate issue and all these things are going to cloud the issue."

Doctor Turberville:

"I think that if we attempt to specify it will lead to interminable specifications. I think that the best thing we can do is state principles. I agree with Dr. Dyrenforth very much that such specifications will only confuse and cloud the issue. I think that we had better stick to the original resolution. It was evidently thought out very carefully. In other words everybody, every doctor who practices in the hospitals is a doctor whether he is doing obstetrics or what not. Whatever department he occupies that constitutes the practice of medicine to the full extent. Pathologists, radiologists, anesthetists, they are all practicing medicine. It makes no difference. We should stick to principles or we get into confusion. I agree with the thought that Doctor Flipse brought out, but at the same time I think we should not get into complications."

Dr. Leland Carlton:

"Some physicians have asked our committee to define the practice of medicine. I don't think it is up to our committee. I think it is up to the American Medical Association to tell us what the practice of medicine is."

Doctor Stewart:

"I just want to ask one question. It is the custom in Miami to employ a house man, and a great many hospitals pay that man $75.00 a month and 50% of the fees he collects for emergency treatments. According to this resolution if passed these hospitals would no longer be allowed to do that. Mr. Chairman, I think this is one of the most important things to come up before the House of Delegates. From the standpoint of our own hospitals and all other hospitals, it is a big point. I personally don't want to go into a hospital that does not have a pathologist. I personally don't want to go into a hospital with my patients if they do not have these services, and yet I don't agree with hospitals practicing medicine. I believe we should think this resolution over very carefully and if it is not satisfactory then we should get up another one; possibly it will require an amendment to the constitution."

Motion by Dr. Stewart that this Association table final action on this matter until the next meeting of the House of Delegates.

The above motion then amended to include that the secretary be instructed to have mimeographed copies of this resolution circulated among the delegates prior to the next meeting of the House of Delegates.

Seconded and carried.

Report of the Committee on Publication by the Chairman, Dr. Walter C. Jones, as follows:

REPORT OF COMMITTEE ON PUBLICATION

We are receiving more and more papers and I think a much better class of papers this year than in some preceding years. Due to the fact that we are receiving more papers we hope to be able to raise the standard of our publication. So if the committee in the future should become a little more severe in its criticism don't feel hard. It is because we are simply trying to raise the standard of publication in the Journal. The Florida Medical Journal publishes fifteen hundred copies each month and these are sent to all parts of the world. The practice of medicine in Florida is judged to some extent by the Journal we are putting out.

I would again reiterate the suggestion that was made last year, that you spend a little more time in the preparation of your papers. So often we find a paper with a lot of good thought and material in it, but poorly written. This is not because the man does not know how to write but because he has not taken the time to write. Very often a paper that has to be re-written, re-studied, re-hashed is not fit for publication; that is, it would not make a nice paper for publication. If we send a paper back and ask that you re-study it, please return it and we will get it in proper form for publication after you have done the best that you can. A lot of us can not write, but there are people in the State who do know how to write and they can help us. With their help you can present your subject in a form that will be a credit to you.

We realize that we have perhaps not had much original work in Florida, such work being done more often in medical centers, etc.

But when you do have original work, give us a break. The standard of practice in Florida to a great extent is going up.

In regard to publications, we would like you to submit to us with your papers as complete a bibliography as it is possible for you to obtain in connection with it. These bibliographies can be obtained from the American Research Department.

At the present time you can get help and if you have something worth publishing it is worth while for you to send it to the Florida Medical Journal.

Respectfully submitted,
WALTER C. JONES, Chairman
SHALER RICHARDSON,
HERBERT E. WHITE.

On motion, the report of the Committee on Publication was adopted.

The following report of the Committee on Public Relations was read by Dr. J. Ralston Wells, Chairman:

REPORT OF COMMITTEE ON PUBLIC RELATIONS

This year the Public Relations Committee has confined its attentions to putting on a broadcast over the Florida State College radio station, WRUF, every Sunday evening except in July and August. There have been thirty original essays; the others have been rewrites of material furnished from the Public Relations Committee files on hand. The committee has furnished, from time to time, material for talks given by various physicians. We have had response from the radio audience requesting copies of talks delivered. We have handled requests from different individuals asking for specific advice on their ailment that seemed to have been touched upon by the essayists. The latter have been invariably referred to their family physician without specific advice.

The members of the committee have all been active equally, each member furnishing speakers for given dates. The men throughout the state have cooperated very well, both in writing articles and delivering them over the station except at times when it has been found at the last minute to be impossible.

Permanent Electric Transcriptions of Medical Talks

Since the Public Relations Committee came into being and radio broadcasting became its main objective there have been numerous other broadcasting stations throughout the state take up and further the work. Bearing in mind the difficulty now and again encountered, in furnishing speakers and topics at given times, we think that the State Medical Association could aid, both its own broadcasting and the various other stations, by recording the talks as given over WRUF and disseminating them to other stations in regular order or upon request. During the course of the year there would be at least forty-eight censored, true and timely articles for a radio library that could be utilized at any time for not only medical broadcasts but could be loaned, under supervision, to local stations wishing to put on certain medical talks, aiding our Women's Auxiliary, our State Board of Health, women's clubs and similar organizations. These records would be made by WRUF through the courtesy of Director Garland Powell without expense other than actual cost of records used. These records would cost approximately $5.75 for a 15-minute address. The above mentioned price could probably be lessened if several talks were combined on one record. This would be a matter of arrangement and I am assured it is very practical. Every man has, more or less, a reluctance in talking medicine in his home town and would be more inclined to use the radio if he did not wish to appear personally. We therefore, request an appropriation from the State Association of $250 to enter this field of medical education.

I wish to take this opportunity to thank the University of Florida for its cooperation and particularly the director, Garland Powell, and his associates for their wholehearted advice, aid and cooperation. The station has notified us when our speakers failed to get their manuscripts in on time, have read manuscripts at the last minute when a medical engagement kept the speaker from appearing and have helped, by courtesy, those who were unused to speaking over the radio. I wish, also, to thank each member of my committee who have willingly and adequately carried out the committee plans, each one contributing his share to making it a creditable year.

Summary: We request that a letter of appreciation be sent to Director Garland Powell

and his associates for making it possible to carry on our work. Second, that a sum not less than $250 be allocated for use of the Public Relations Committee in recording medical talks for the year 1938 and 1939.

The attached itemized bill for necessary postage, telephone and telegraph, throughout the year is included for payment.

Respectfully submitted,
J. Ralston Wells, Chairman
W. L. Ashton
Hubert A. Barge
George R. Creekmore
Allen M. Ames
Eugene S. Gilmer

Motion by Dr. Herbert E. White that the Florida Medical Association allow an amount not to exceed $250.00 to produce these records.

Amendment by Doctor Flipse that the word "produce" be changed to "obtain."

Seconded and carried.

Motion by Doctor Coplan of Miami that the Secretary-Treasurer be instructed to meet the expenses of $26.54 as Doctor Wells had outlined in the report.

Motion seconded and carried.

Report of Public Relations Committee adopted.

Report of the Committee on Necrology read by the Chairman, Dr. George W. Potter, as follows:

REPORT OF COMMITTEE ON NECROLOGY

During the past year, our Association lost, by death, the members whose names are listed below:

L. M. Anderson, Lake City
Herbert W. Bearce, Port Orange
B. Auxford Burks, Winter Park
Calvin D. Christ, Orlando
Charles D. Cleghorn, Miami
Paul Eaton, Jacksonville
Davis Forster, New Smyrna
Grover C. Hardie, Fort Pierce
M. D. Hartman, Homestead
A. S. Hawkins, Clermont
J. J. Kindred, DeLand
J. C. Knight, Plant City
Perry M. Lewis, Orlando
Adolph B. Quasser, Jacksonville
John D. Raborn, Trenton
Floyd H. Randall, Van Wert, Ohio
J. Knox Simpson, Jacksonville
J. F. Williams, Monticello

When possible, obituaries have appeared in the Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

May we, at this time, stand in a moment of silence, in reverence and respect to the memory of our departed colleagues.

Respectfully submitted,
George W. Potter, Chairman
Chadbourne A. Andrews
Eustace Long
William W. McKibben
Charles L. Park
B. A. Wilkinson

Report of Committee on Necrology adopted.

The report of the Committee on Medical Postgraduate Course was read by the Chairman, Dr. T. Z. Cason, as follows:

REPORT OF COMMITTEE ON MEDICAL POSTGRADUATE COURSE

From June 27 through July 2 the Sixth Annual Graduate Short Course for Doctors of Medicine will be held at the Osceola Hotel in Daytona Beach. Daytona Beach was selected after a careful analysis of the answers to the questionnaire which was sent out to the component societies and to the councilors.

The committee feels that we as well as the officers of the Florida Medical Association have made every possible effort to reach individual doctors and make them realize both the value of postgraduate education and the high type of lectures we offer. In spite of our attempts, the enrollment has increased slowly. The repeats each year, indicate, however, the appreciation of those men who have taken the trouble to attend. As a departure from the past we have employed a professional publicity manager who, under our direction and censorship, is attempting to make the public "graduate-short-course-conscious." We feel that if the laymen in individual communities appreciate the value to their physicians, they will be much more tolerant of their absence from home to attend the course.

The attendance last year, as previously not-

ed in the Journal was 136. The total cost to the Florida Medical Association for the past five years has been only $132.92. This has been due in no small part to the cooperation and assistance of the Florida State Board of Health. We also recognize the aid of the University of Florida. After much discussion and considerable deliberation, the committee decided to withdraw its affiliation with the University of Florida. This was done in a tactful and highly satisfactory manner. The University was perfectly willing to continue the relationship on the old basis but this did not seem satisfactory to us. We feel sure that if there is any desire or need for further affiliation with the University, it can be brought about satisfactorily.

The committee is very solicitous of your suggestions and criticism.

The program this year is equal if not superior to any before. Copies of the schedule may be secured at Registration Desk.

Respectfully submitted,

T. Z. CASON, Chairman
GEORGE L. COOK
WILLIAM W. GEORGE
FRANK D. GRAY
G. C. TILLMAN
JOHN S. TURBERVILLE

On motion made, seconded and carried the report of the Committee on Medical Postgraduate Course was adopted.

The report of the Committee on Cancer Control was read by Dr. Gerry R. Holden, as follows:

REPORT OF COMMITTEE ON CANCER CONTROL

Your Committee on Cancer Control begs to report that its major activity during the past year has been in collaboration with and advisory to the Women's Field Army, an organization originated and sponsored by the American Society for the Control of Cancer.

For your information it is worth while to report the details of the organization of the Women's Field Army because during the coming year you will hear more from it.

In 1935 the American Society for the Control of Cancer conceived the idea of organizing groups of women throughout the entire country who would have the spread of the cancer knowledge as their chief objective. Directing the organization was Dr. Clarence D. Little, with Mrs. Margaret Illig as National Field representative. A fundamental principle of the Field Army is that in each state the State Medical Society, through its Cancer Control Committee, shall supervise its organization and direct its activities. In Florida, Mrs. Ralston Wells was chosen as State Commander, and in the summer of 1936 an organization meeting was held in Orlando, attended by interested women from practically every woman's organization in the State. Doctor Holden and I represented the Cancer Control Committee.

The organization as set up for Florida, included a State Commander and six Captains, one in each of our committee districts. The complete organization includes a lieutenant in each county or group of counties corresponding to the territory of our County Medical Societies.

A list of speakers has been furnished the State Commander from the medical profession who have consented to serve when called on for cancer programs. Also, local cancer committees from some of the County Societies have been designated, these to serve as contact men for the local lieutenants of the Field Army. The objective of this whole setup is to utilize all the woman power of the State toward the spread of authentic information about cancer, but at the same time to safeguard against thoughtless, harmful or unethical activities which might develop if there were not a close supervision of any lay group.

In addition to the above reported work your committee has put on programs either through its own membership or other designated speakers in Jacksonville, Palatka, St. Augustine, Tallahassee, and Crawfordville, with radio broadcasts over Jacksonville, St. Augustine and Tallahassee radio stations.

Respectfully submitted,

F. CLIFTON MOOR, Chairman
SAMUEL C. HARVARD
GERRY R. HOLDEN
NORVAL M. MARR
LAUCHLIN M. ROZIER
ADRIAN M. SAMPLE

SUPPLEMENTARY REPORT CANCER CONTROL COMMITTEE

The foregoing report of Doctor Moor, Chairman of the Cancer Control Committee, was written several weeks ago before the Women's Field Army had its drive for membership during April. It is therefore, pertinent to add further data regarding the present situation of the Women's Field Army in Florida.

As a result of the drive in April, the Army is now organized in 17 counties with 37 separate units at work. There are about 120 workers in the field. A list of 34 doctors has been compiled who are ready to assist in this work as speakers. Radio broadcasts are being put on over every station in the State, some of them with daily features. Over 20,000 pieces of literature had been sent out from headquarters in Daytona Beach, up to May first. The April number of the Florida Health notes, a publication of the State Board of Health, is devoted to cancer with an especial article on the Women's Field Army.

There have also been many other activities along this line of education. Remarkable cooperation has been secured from many agencies. Good publicity on the part of the press has been secured. The Florida Light and Power Company and the Tampa Electric Railway Company are worthy of mention in this regard.

Through the assistance of Doctor Spoto, County Health Director of Tampa, the Latin Clubs of that city have been contacted and literature in Spanish distributed.

All of these activities and many others too numerous to be detailed here have been initiated either by the Women's Field Army, individual members of the Cancer Control Committee and individual physicians, not members of the Cancer Control Committee, who have been interested in the subject as a matter of public health.

The Cancer Control Committee as such has not been active. During the past two years the committee has had no meeting at which there was a full attendance, nor have the activities mentioned above been the result of any deliberations on the part of the entire committee.

This is an exceedingly important committee. It is the executive committee of the Women's Field Army. The activities of this organization should be directed by the committee as a whole, and not by individual members. It is imperative that the Women's Field Army have some such direction.

Therefore, we suggest that inasmuch as this committee as a whole has not been active, that it be disbanded and the President form a new committee.

Respectfully submitted,
Gerry R. Holden, Acting Chairman
Norval M. Marr
Adrian M. Sample
Samuel C. Harvard
Lauchlin M. Rozier

It was moved, seconded and carried that the above reports be adopted.

The following report of the Committee on Medical Economics was read by Dr. J. C. Vinson, Chairman:

REPORT OF COMMITTEE ON MEDICAL ECONOMICS

The last report of your Committee embodied recommendations that received the approval of your Executive Committee.

These special recommendations revolve around the establishing of an economic bureau. This Committee recommended in its report that this bureau be established in one county as an experimental laboratory and should the feasibility of the plan be proven, then there could be established in each county its own bureau.

Your Executive Committee gave its approval of the plan with the distinct understanding that your Economics Committee find ways and means, whereby the first county unit would be established without the financial backing of the State Medical Association. Your Executive Committee agreed with this Committee that in raising the money, the Florida Medical Association should not lose control of its bureau.

Your Committee has been offered the necessary funds from different philanthropic organizations, but the acceptance of any one of these offers would have meant the loss of control to the Florida Medical Association. It is a source of keen disappointment to your Com-

mittee that we cannot at this time state that the first bureau has been established.

However your committee is proud to report that the necessary funds for the establishing of its first county unit has been promised and that the funds will be available within 90 days.

Your committee is confident that in its next annual report workable concrete evidence can be submitted that will prove to the world that the control of the practice of medicine in the State of Florida has been retained by the Medical Profession.

Respectfully submitted,

JOHN C. VINSON, Chairman
ALBERT H. FREEMAN
HEWITT JOHNSTON
LOUIE M. LIMBAUGH
DANIEL A. MCKINNON
GERARD RAAP

Motion made, seconded and carried that the above report be adopted.

The report of the Committee on Venereal Disease Control was not read due to the absence of Dr. E. T. Sellers.

The following report of the Committee on Inter-Relationship was read by Dr. W. M. Rowlett, Chairman:

REPORT OF INTER-RELATIONSHIP COMMITTEE

During the last year the Committee on Inter-Relationship has held several conferences with the allies of the medical profession; namely, dentists, pharmacists and nurses. We have gone over the proposed legislative program of the Florida Graduate Nurses' Association with the chairman of their legislative committee. They are working on a very constructive program. The dentists and pharmacists have not yet adopted their legislative program.

Through the cooperation of the Committee on Scientific Work, we have arranged to have the President of the State Dental Association our guest and make an address at the annual banquet. For several years it has been the custom of the Dental Association to invite the president of the Florida Medical Association to appear on its programs. Your committee believes that the interchanging of speakers among our allied organizations is a good thing and should be encouraged.

Your committee has endeavored to be cautious in dealing with the recent political campaign. However, your chairman feels that he was fortunate to be able to interview, personally, every candidate for the Supreme Court. He feels that these interviews are going to result in a better understanding and a quicker dispatch of medical cases coming before that body in the future, recalling that every case we have had before the Supreme Court during the last ten years was lost on technicalities.

Respectfully submitted,

W. M. ROWLETT, Chairman
THOMAS H. BATES
HERBERT L. BRYANS
LOUIS M. ORR
EDWIN C. SWIFT
CORBETT E. TUMLIN

Motion to adopt the above report, seconded and carried.

The following report of the Committee on Tuberculosis and Public Health was read by Dr. M. Jay Flipse, Chairman:

REPORT OF COMMITTEE ON TUBERCULOSIS AND PUBLIC HEALTH

This committee has held four meetings during the year—October 28, 1937, January 3, April 25 and May 9, 1938.

The committee sponsored and participated in the second annual Tuberculosis Institute for Negro Physicians held in Miami, July 5-23, 1937. This was made possible through the financial cooperation of the Julius Rosenwald Fund, Florida Tuberculosis and Health Association, Florida State Board of Health and the Dade County Tuberculosis Association.

This committee participated in the Short Course for Physicians held in Orlando, June 21-26, 1937. A Symposium on Tuberculosis was sponsored by the committee and Dr. P. N. Coryllos, New York, internationally known chest surgeon, was the guest speaker. He was brought to Florida through the financial cooperation of the Florida Tuberculosis and Health Association. Other speakers were Dr. T. M. Palmer, Jacksonville and Dr. R. D. Thompson, superintendent and medical director, State Tuberculosis Sanatorium.

The committee served in an advisory capacity to the State Tuberculosis Board in the selection of Dr. R. D. Thompson as superintendent and medical director for the State Tuberculosis Sanatorium at Orlando. Numerous conferences were held with Doctor

Thompson and members of the Board relative to plans and policies for the institution.

The committee has served an an advisory capacity to the Division of Tuberculosis, State Board of Health and conferred with Dr. A. J. Logie, its director, approving the tuberculin testing and x-raying program in high schools. It also considered and approved the tuberculin testing of indigent contact and suspect cases referred by local physicians and the subsequent x-ray examinations.

The committee acted in an advisory capacity to the Florida Tuberculosis and Health Association in approving films, exhibits, charts, pamphlets, posters and other matter for distribution to lay and selected groups.

Respectfully submitted,

M. Jay Flipse, Chairman
William C. Blake
L. Sydnor Laffitte
Duncan T. McEwan
John C. McSween
Harry F. Watt

Motion to adopt this report, seconded and carried.

The report of the Committee on State Controlled Medical Institutions was not read due to the absence of Dr. H. Mason Smith.

The following report of the Committee on Maternal Welfare and the Committee on Child Health was read by Dr. Homer Pearson:

REPORT OF COMMITTEE ON MATERNAL WELFARE AND CHILD HEALTH

The committee has had a very inactive year, due primarily to the fact that for a major portion of the past fiscal year, the State Board of Health has been without a Director for its Bureau of Maternal and Child Health. However a Director has been selected and he is now doing excellent work.

On January 17 and 18 of this year, the chairman of the committee attended, by invitation, a conference on the "Better Care of Mothers and Babies." This conference was held in Washington under the direction of the Children's Bureau of the Department of Labor. The full report of the proceedings of the conference, with reports of its special committees, can be obtained through the Board of Health.

The committee in conjunction with the State Board of Health, is carrying on a survey of the maternal deaths in Florida during 1938. The information obtained on death certificates is not complete enough to form any definite conclusions. Therefore, the physician who signs the death certificate is asked to fill out a questionnaire, giving in detail all the information he has on the case. This information is studied and statistics compiled, which we believe will give us something definite to work on. Reports upon the progress of this survey will be made from time to time in the Journal.

All the County Societies have been notified that such a survey is in progress.

Copy of the questionnaire will be furnished on request.

Respectfully submitted,
Homer L. Pearson, Chairman
Committee on Maternal Welfare
Luther W. Holloway, Chairman
Committee on Child Health

Motion to adopt the above report seconded and carried.

The following report of the Advisory Committee to the Woman's Auxiliary was read by Dr. Gordon Ira, Chairman:

REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The Advisory Committee met with Mrs. S. M. Copeland, President of the Auxiliary, and her board, in July, at Orlando. As a result of the meeting, the following charge was sent to each county auxiliary by our President, Dr. Edward Jelks:

Dear Auxiliary Members:

The Woman's Auxiliary to the American Medical Association has made itself very definitely known in parts of the United States. We feel that the Florida Auxiliary has not ceased to grow and in handing you the following charges for the coming year, I trust that they will, by unifying your work, enable you to continue your growth.

A new charge, and the one activity to be stressed this year, concerns an all-day health institute. The possibilities of distributing health information at this all-day meeting are large and the success with which it meets will depend upon the enthusiasm with which it is put on.

CHARGES

1. Health Institute: To be an all-day meeting of all women's organizations of the county, where numerous short talks on different health topics are to be given by recognized authorities. Further specific suggestions may be obtained from your president or program chairman.

2. Cooperate with the cancer program, under the direction of Mrs. Ralston Wells.

3. Allow two minutes at each meeting for the presentation of Hygeia information.

4. Endeavor to see that the American Medical Association broadcasts of health dramas are secured by your station.

5. Urge attendance at the State and National conventions.

Wishing for you a very successful year, I am

Very respectfully,

EDWARD JELKS, M. D., *President*
Florida Medical Association

Probably the outstanding accomplishment this year was the Health Institute, which was copied after the Philadelphia Auxiliary, having had them in Philadelphia for a number of years. Some of the institutes in Florida have been exceptionally well attended. The talks have been received with enthusiasm by the laity and undoubtedly a great deal of good has been accomplished. In some of our cities it undoubtedly will become a permanent institution.

Respectfully submitted,

GORDON H. IRA, Chairman
J. L. CHALKER
JOSEPH HALTON
L. C. INGRAM
W. C. ROBERTS
A. L. WALTERS

It was moved, seconded and carried that the above report be adopted.

The following report of delegates to the American Medical Association was read by title except for the final paragraph by Dr. Meredith Mallory:

REPORT OF DELEGATES TO A. M.A.

The 88th Annual Session of the American Medical Association held at Atlantic City, N. J., June 7-11, 1937 was the largest meeting ever held by this body. Being held near to so many centers of medicine and in America's most famous resort city 9,764 were registered —60 from Florida.

The House of Delegates was in session more than at any time for many years. A special meeting was held for a talk by U. S. Senator J. Hamilton Lewis of Illinois. To sum his speech up briefly, he said that there was to be a new order of things in this country and the medical profession would have to become part of it. The members were no longer individualists but would become officers of the U. S. Government.

The most important resolution was presented by Dr. S. G. Kopetsky of New York, which was as follows:

Whereas, the house of delegates of the Medical Society of the State of New York in annual session at Rochester, 1937, adopted certain resolutions which carried instructions to its delegation to the House of Delegates of the American Medical Association; and

Whereas, these resolutions concern the following principles and proposals anent the development of a national health program and the special circumstances under which the delivery of a high quality medical care to the American people may be evolved under conditions within the framework of adopted policy of the American Medical Association; and

Whereas, these principles and proposals are as follows:

PRINCIPLES

1. That the health of the people is a direct concern of government, and a national public health policy directed toward all groups of the population should be formulated.

(a) In the formulation of such policy the opinions and suggestions of organized medicine should be given preference.

(b) That the House of Delegates of the American Medical Association create a group which shall formulate the principles and proposals of a National health policy to be submitted to the government.

2. That adequate medical care is an essential element of public health and local, state and federal governments need to supplement present efforts of the medical profession to provide it.

(a) That the House of Delegates of the American Medical Association establish a working definition of the term "adequate medical care" suitable for the purpose of discussing national legislation and social legislation.

3. That the problem of economic need and the problem of providing adequate medical care are not identical and may require different approaches for their solution.

(a) Principle 3 implies that the problem of providing the individual with the means of securing medical care —that is, the economic needs—and the problem of distributing medical services are not identical; that these problems of economic needs should be approached separately from those of distributing medical services to the people.

PROPOSALS

1. That the first necessary step toward the realization of the above principles is to minimize the risk of illness by increasing preventive efforts through extension of public health services, federal, state and local.

(a) That the extension of federal, state and local preventive health measures is approved, provided it meets the needs of a given situation in the opinion of the medical profession in the locality affected and provided it integrates to the greatest possible extent the private practitioner of medicine in the development of preventive health services.

2. That the immediate problem is provision of adequate medical care for the medical indigent, the costs to be met from public funds.

3. That public funds should be made available for the support of medical education and for studies, investigations and procedures for maintaining the present high standard of medical practice. This support shall have the majority opinion of organized medicine to recommend it. If this is not provided for, the provision of adequate medical care may prove impossible.

4. That public funds should be available for medical research as essential for high standards of practice in both preventive and curative medicine.

5. That public funds should be available to hospitals that render services to the medically indigent and for laboratory diagnostic and consultive services.

(a) With the provision that these consultive and laboratory diagnostic services shall be established only in regions where the medical profession approves the need for same and after consultation with the local medical profession in the area affected.

6. That in the allocation of public funds existing private institutions should be utilized to the largest possible extent and receive support as long as their service is in accord with the above proposals.

(a) That insofar as the allocation of funds is concerned for these institutions, they should not be made on a prorata population basis but should be limited strictly by the needs of given institutions in specified localities and the allocation should have the approval of the medical profession in the locality in which the institutions are located.

(b) That in the selection of existing institutions to which public funds may be allocated their rating and their needs shall be measured by the standards of the Council on Medical Education and Hospitals of the American Medical Association; and that no public funds should be made available to existing institutions against and contrary to the majority opinion of the medical profession in the locality in which they exist.

7. That the investigation and planning of the measures proposed and their ultimate direction should be assigned to experts.

(a) It being recommended that the various subdivisions of the American Medical Association, namely, its national, state and county components, furnish to the government on request lists of experts in their communities to carry out these principles and proposals.

(b) That the word "expert" is taken to mean a man especially qualified by experience in his specific field. Nominations of these experts should be by units of organized medicine. The nominations and recommendations by organized medicine should be given preferential consideration by government in making its selection.

8. That the adequate administration and supervision of the health functions of the government, as implied in the above proposals necessitates in our opinion, a functional consolidation of all federal health and medical activities under a separate department.

9. That we who subscribe to the above principles, proposals and recommendations hold the view that compulsory health insurance does not offer a satisfactory solution on the basis of these principles and proposals and repeat our objections to its enactment in this country; therefore be it

RESOLVED, that the House of Delegates of the American Medical Association endorse the principles, proposals and recommendations just cited, and be it further

RESOLVED, that the House of Delegates authorize the formation of a committee which shall, in conformity to the above, formulate a national health policy for submission to the government, and further be empowered to confer with government agencies and also with any other medical groups so that differences in conception, definition of terms and applicability of principles and procedures may be ironed out in conference regarding those matters in the above principles and proposals which are of national scope and to the end that they may be enacted.

This created considerable discussion both in the House and in the reference committee. The House of Delegates disposed of this in the following manner:

1. Your reference committee has carefully considered the Resolutions on the Development of a National Health Program, introduced by Dr. Samuel J. Kopetzky in behalf of the New York delegation, and has held hearings at which the details of the principles and proposals were freely discussed.

The Board of Trustees has already reported to this House of Delegates its considered opinion pertaining to the reorganization, in one consolidated department, of the activities of the federal government having to do with the promotion of health and the prevention of disease. Copies of this statement, as printed in *The Journal* and in the handbook of the House of Delegates were transmitted to the President of the United States and to others in official position in Washington, and the attention of constituent state medical associations was especially called to the action of the Board, as follows: "Recognizing that committees of the Senate and of the House of Representatives of the United States Government and a special committee appointed by the President are at this time concerning themselves with the reorganization of government activities with a view to greater efficiency and economy, and recognizing also that the President, in his opening address to Congress, indicated that he would shortly present to the Congress recommendations for such reorganizations of governmental activities in the executive branches, and recognizing moreover the great desirability that all activities of the federal government having to do with the promotion of health and the prevention of disease might with advantage be consolidated in a single department which would not however be subservient to any charitable, conservatory or other governmental interest. It has been repeatedly said that public health work is the first problem of the state. It is the opinion of the Board of Trustees that health activities of the government, except those concerned with the military establishments, should not be subservient to any other departmental interests. This reorganization and consolidation of medical departments need not under present circumstances, involve any expansion or extension of governmental health activities but should serve actually to consolidate and thus to eliminate such duplications as exist. It is also the view of the Board of Trustees that the supervision and direction of such medical or health department should be in the hands of a competently trained physician, experienced in executive administration."

Since the House of Delegates during this session has already approved this action of the Board of Trustees, your reference committee deems it unnecessary to submit for your consideration that portion of the resolutions which deals with this subject.

Your reference committee recognizes that certain principles stated in the resolutions presented by Dr. Kopetzky have been considered by the House of Delegates on previous occasions and are matters of record. These include for example, the recognition of the primary importance of public health, the opposition to compulsory sickness insurance and the separation of the problem on economic need and the distribution of medical service.

The Board of Trustees has given careful consideration to the extension of medical service to the indigent, as indicated in the following statement, which was contained in the report of the Board of Trustees which was approved by this House during its session June 8, 1937:

"In the past, the medical profession has always been willing to give to its utmost for the care of those unable to pay. The available evidence indicates that today throughout the United States the indigent are being given a high quality of medical care and medical service. Nevertheless, the advances of medical science have created situations in which a group of the population neither wholly indigent nor competent financially find themselves under some circumstances unable to meet the costs of unusual medical procedures. The Board of Trustees of the American Medical Association points out the willingness of the medical profession to do its utmost today, as in the past, to provide adequate medical service for all those unable to pay either in whole or in part. Members of the medical profession, locally and in the various states, are ready and willing to consider with other agencies ways and means of meeting the problems of providing medical service and not able to meet the full cost thereof. These are problems for local and state consideration primarily rather than problems of federal responsibility. The willingness of the medical profession to adjust its services so as to provide adequate medical care for all the people does

not constitute in any sense of the word an endorsement of health insurance, either voluntary or involuntary, as a means of meeting the situation."

The American Medical Association is cognizant of the medical needs of the people of the United States and is genuinely interested in all plans for providing and distributing medical care. The records, reports, source material and experience of the Association are of great value. They are at the service of agencies contemplating the development and operation of plans for medical care. These factual data, source material and experience are readily available for use in promoting and protecting the health of the American people.

Your reference committee recommends that the bureaus, councils and committees of the Association continue their studies of the need for the methods of distributing medical care, to the end that the American Medical Association shall continue to do everything possible to promote and to protect the health of the American people.

The American Medical Association reaffirms its willingness on receipt of direct request to cooperate with any governmental or other qualified agency and to make available the information, observations and results of investigations together with any facilities of the Association.

In regard to giving hospitalization insurance it was recommended that the contract benefit be limited to room, bed, board, ordinary nursing facilities and routine medicines.

The terms "free choice of physicians" as applied to contract practice was amended to mean "that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patient and physician when no third party has a valid interest or intervenes. The interjection of the third party who has a valid interest or who intervenes does not *per se* cause a contract to be unethical." A "valid interest" is one where, by law or necessity, a third party is legally responsible either for cost of care or for indemnity. "Intervention" is the voluntary assumption of partial or full financial responsibility for medical care. Intervention shall not proscribe endeavor by component or constituent medical societies to maintain high quality of service rendered by members serving under approved sickness service agreements between such societies and governmental boards or bureaus and approved by the respective societies.

The House of Delegates passed a resolution pledging the support of the A. M. A. to any movement looking toward the promotion of sound and effective legislation, federal and state, for the protection of the public against fraud and deception in the manufacture, distribution and sale of foods. drugs, prophylactic, diagnostic and therapeutic devices and cosmetics.

Two definitely new procedures were adopted by the House of Delegates. A resolution was passed recommending its development of a distinguished service medal with citation to be presented each year at the close of the annual session to a physician who has rendered such service for the advancement of the Art and Science of Medicine. A resolution was also adopted providing for the selection of a meeting place three years beyond the time of selection. There were many reasons for this change, but the most important was the fact that the meetings of the A. M. A. have grown so large that there are but few cities in the United States which can accommodate them satisfactorily.

The General Scientific meetings commanded tremendous audiences. More than 300 papers were read in the scientific sessions.

The Scientific Exhibit has come to represent what is probably the most noteworthy of the many extraordinary features of the annual sessions.

While not a report of the Proceedings of the House of Delegates it is our desire to call attention to an editorial in the Journal of the American Medical Association of October 16, 1937, and also to various activities of the so-called Committee of 430 including the address of Doctor Means before the American College of Physicians.

In conclusion we would like to recommend that this annual report be divided into two parts. (1) A report to the Executive Committee of the Florida Medical Association as to the proceedings, which report shall be made as soon as convenient after the A.M.A. meeting; (2) a report to the House of Delegates of the Florida Medical Association merely showing the attendance of your delegates at the session. This is advised because very few, if any, are interested in hearing this report and if there is anything worthy of reporting it should not wait a year before receiving action.

Respectfully submitted,

MEREDITH MALLORY, M. D.

H. L. BRYANS, M. D.

Doctor Day:

"I believe that Dr. Mallory's recommendation is a fine one."

Motion by Doctor Day that the recommendation contained in Doctor Mallory's report be adopted.

Motion seconded and carried.

Report of Delegates to A. M. A. adopted.

Doctor Jelks:

"I wish to express the appreciation of the Association to the men on these committees for the good work they have done during the past year."

The next order being the presentation of new business, the following resolution was read by Dr. John R. Boling:

(*See second meeting for resolution on General Advisory Board of Past Presidents*).

Resolution held over for final action for twenty-four hours.

Motion by Doctor Summerlin that every member be assessed $5.00.

On motion in the second meeting of the House of Delegates, the discussion was stricken from the records.

Doctor Jelks:

"It seems to the Chair that this is a very important thing and one which should not be voted on in a hurry. Not a man here but who wants the Association to have what it needs to get legislation through in a proper manner. Unless you overrule the Chair, the Chair rules that this will be carried over or postponed until the meeting of the House of Delegates tomorrow, when we will take this question up and decide it."

There being no further business to come before the meeting, on motion duly seconded and carried, the meeting adjourned.

FIRST GENERAL SESSION

The Sixty-fifth annual meeting of the Florida Medical Association was called to order at 1:30 p. m. Monday, May 9 in the Assembly Room of the Columbus Hotel, Miami, by President Edward Jelks.

Invocation by Dr. R. Z. Tyler, Pastor Trinity M. E. Church, South, Miami.

In the absence of the Mayor, Mr. Alvin E. Fuller, City Manager, gave the address of welcome.

Dr. Arthur H. Weiland, President Dade County Medical Society, also delivered an address of welcome.

The following report of our delegates to the Georgia Medical Association Convention was read by Dr. Holden:

REPORT OF DELEGATES TO THE 1937 MEETING MEDICAL ASSOCIATION OF GEORGIA

The meeting was held in Macon, Georgia May 11 to 14, 1937, inclusive.

The first day, Tuesday, May 11, all the time was taken up with the meeting of the House of Delegates at which the reports of the various officers and committees were made.

Your representatives listened to many of these reports and were greatly impressed with the constructive work which they represented. While all the reports were interesting, of especial importance to us were the reports of the Cancer Commission by Dr. J. L. Campbell of Atlanta, Chairman; the Committee on Medical Economics by Dr. J. E. Paullin of Atlanta, Chairman; and the Committee appointed for the Study of Maternal Mortality and Infant Deaths, Dr. H. A. Sharpley, Savannah, Chairman.

Doctor Campbell reported the completion of a most constructive program for cancer control which the State of Georgia had just put into commission.

The reports of Drs. Paullin and Sharpley showed an enormous amount of work in studying conditions throughout the State, especially in the rural districts. Both of these reports gave a rather startling picture of the status of medical care in many of the rural districts.

The regular meeting of the Association opened on May 12, 1937, at 9 a. m. in the Macon Municipal Auditorium.

And here we may add that we Floridians envied the State of Georgia very much in having such an auditorium with space to accommodate a large gathering, and incidental facilities sufficient to take care of various allied interests. We felt that if we had similar buildings in our own State, we would be in better position to solicit meetings from various national organizations which, on account of lack of such facilities, we cannot at present conscientiously invite to our State.

On Wednesday morning the meeting was

opened at 8 o'clock, the first ceremony being the presentation of the President's key to Dr. Minchew of Waycross, President of the Association.

A series of interesting papers by members of the Georgia Association followed and at 11:20 Doctor Upham, President-elect of the A. M. A., gave his interesting illustrated talk on heart disease in middle life. Doctor Abt of Northwestern University, Chicago, followed with an address on Vitamins in Infant Nutrition.

Wednesday afternoon was devoted to the reading of papers while Wednesday evening was taken up by addresses by invited guests, Doctor Craig of Tulane, Doctor McClure of Detroit, and Dr. Olin West, Secretary of the American Medical Association. These were all valuable, especially the address of Doctor West which took up many interesting points in medical economics.

On Thursday, both morning and afternoon were devoted to reading of papers by members of the Association. They were all good, many of them extremely instructive, but it is manifestly impossible to make further comment.

Thursday noon, the President, Doctor Minchew, delivered his address upon "The Responsibility of the Layman in a Public Health Program." This was followed by memorial exercises for deceased members which was conducted by Doctor Mooney of Statesboro, Necrologist of the Association.

On Thursday evening a buffet supper and floor show at the Idle Hour Club, with Dr. Charles H. Richardson as Master of Ceremonies, was one of the outstanding features of the meeting and it was most thoroughly enjoyed by your representatives.

The early part of the next day, Friday, was devoted to reading of excellent papers, while at twelve noon the election of officers took place. Dr. Grady Coker of Canton, Georgia, was elected President-elect. This was very popular, not only with the Georgia members, but also with your delegates. Doctor Coker is well known to many of us in this State who admire him for his professional activities and love him on account of his genial personality.

In conclusion, we would say that we were received at this meeting with the utmost cordiality. Nothing was left undone by the Association and its individual members which would tend to make our visit a pleasant and a happy one, and we do hereby express hearty appreciation to the Medical Association of Georgia for the whole-hearted manner in which we were received.

Respectfully submitted,

HOMER PEARSON, M. D.

GERRY R. HOLDEN, M. D.

Doctor Jelks:

"This year, 1938, the representatives were Dr. Gerry Holden and Dr. Homer Pearson. I will ask Dr. Pearson to tell you about the meeting at Augusta in 1938, and then to introduce the representatives from the Georgia Medical Association."

Doctor Pearson:

"Mr. Chairman, President, Members of the Florida Medical Association:

"Doctor Holden has given you a very delightful report of the activities of the meeting at Macon, but I would like to remind you that my report is strictly from a fraternal standpoint and not so much from the scientific.

"The meeting in Augusta was held April 26, 27, 28, and 29, 1938, just two days of which I remember well. Three years ago when I went to Savannah as a fraternal delegate from Florida, I went alone. This year when I went to Augusta Doctor Holden and I went. The reports have been so gratifying that when we started to Augusta there were six, and if I have been informed correctly the next meeting of the Georgia Medical Association will be in Atlanta and they will probably have to reserve the facilities of one of the hotels to accommodate the representatives from Florida next year.

"The first day of the convention was spent by your delegates in getting to Augusta, or most of it. That afternoon we were all very tired and very desirous of some refreshments and we were very cordially invited to attend the 'Tea' given by the President of the Georgia Medical Association. We went over and after we partook of the 'tea' we all felt a great deal better. It was most gratifying to me that it was such excellent headache remedy. Some of the men will remember that I arrived in Augusta with a very special headache but this did not last long after the 'tea', and then I spent most of the afternoon with some of the others in trying to collect funds for the dele-

gation. How successful that was we need not mention at this time. All in all, we might say that the visit to Georgia was most delightful and I want to put in my bid at this time for reappointment to the convention in Atlanta.

"We are very glad indeed to have with us this afternoon as a representative of the Georgia Medical Association, Dr. Arthur G. Fort, who is not a stranger. I cannot remember when he was not either a member of this Association or a fraternal delegate. It is with great pleasure that I introduce to you Dr. Arthur G. Fort, of Atlanta, who in turn will introduce to you the other Delegates from Georgia."

Doctor Fort then introduced Dr. T. C. Davidson of Atlanta, and Dr. Charles Andrews of Canton, the other delegates from Georgia.

Mr. C. P. Loranz, Secretary-Manager, Southern Medical Association was introduced by President Jelks.

President Jelks made the usual announcements and called attention to some of the special features of the convention that had been prepared for doctors and guests.

There being no further business to come before the meeting, on motion duly seconded and carried, the meeting adjourned.

FIRST SCIENTIFIC ASSEMBLY

The Scientific Assembly convened at 2:30 p. m. Monday, May 9, in the Assembly room of the Columbus, Hotel, with Dr. Leigh F. Robinson presiding.

The following papers were read and discussed:

1. "Preoperative and Postoperative Care in Intestinal Obstruction," Dr. Harrison A. Walker, Miami Beach.

2. "Quinine Blindness in Children," Dr. Luther W. Holloway, Jacksonville.

3. Dr. Carol C. Webb of Pensacola was unable to be present to read his paper on "Hand Infections."

4. "Frequent Causes of Prolonged Disability in Fracture Treatment" (lantern slides), Dr. M. Paul Travers, Miami.

SECOND SCIENTIFIC ASSEMBLY

The Second Scientific Assembly was held Tuesday, May 10, 9:00 a. m., Dr. R. H. Knowlton presiding.

The following papers were read and discussed:

5. "Insulin Shock Therapy." Dr. A. L. Huskey, Chattahoochee. (Read by title only.)

6. "The Relationship of Carcinoma of the Larynx to Precancerous Lesions," (lantern slides), Dr. R. E. Repass and Dr. C. S. McLemore, Miami Beach.

7. "Management of Sinusitis" (lantern slides), Dr. Orville N. Nelson, Bay Pines.

SECOND GENERAL SESSION

The Second General Session of the Florida Medical Association was called to order at 11 a. m., Tuesday May 10, 1938 in the Assembly Room of the Columbus Hotel.

President Jelks in the Chair.

Doctor Jelks:

"The medical meetings of the Florida Medical Association are always helped by the cooperation or through the cooperation of the commercial exhibitors. These gentlemen come down and pay to our organization certain monies which are used to carry on the meeting. They have as you know a series of very fine exhibits, and I hope that you will take time to go up and visit these gentlemen. They represent various commercial houses throughout the country."

First order of business, reports of officers and committees.

The following combined report of Secretary-Treasurer-Editor, and Managing Director, was read by Dr. Shaler Richardson:

REPORT OF SECRETARY, TREASURER, EDITOR OF THE JOURNAL, DR. SHALER RICHARDSON, AND MANAGING DIRECTOR, DR. STEWART THOMPSON

To the President and Members of the Florida Medical Association in Session at Miami, Florida:

We are happy to report that the finances of your Association are in much better condition than was estimated last year when the decision was made by this body on recommendation of the Executive Committee, to engage the services of a full-time managing director. It was estimated that the Association's income would be $1,787.25 short of what would be needed to carry on the work throughout the year. Through special efforts in an en-

larged program, there was a slight increase in finances, instead of the anticipated deficit. The financial statements show $889.06, disbursements over income. This, however, is offset by the sale of Medical Directories, amounting to $557.00, which were delivered but not paid for at the time the books were closed; and the purchase of addressograph equipment amounting to $430.67, which was authorized the previous year but paid for during this year. With the exception of these two items, all outstanding obligations for the year are paid, with a balance left over of $98.61.

Your officers have struggled diligently to increase the revenue in order that the enlarged program and greater service to the doctors might be carried on without additional expense to the members, and that the savings of the Association might be left untouched. Additional revenue was secured by increasing the advertising in the Journal. The increase in advertising amounted to $1,325.73. Subscriptions to the Journal and sale of individual Journals amounted to $77.30. The increase in dues collected over the previous year was $1,967.50 The sale of the Medical Directory paid for its printing cost, leaving a nice balance as profit. In addition, it paid for one free copy for each member of the Association.

Your secretary attended five of the six medical district meetings and outlined the work of the Association as being carried on from the headquarters office. Your managing director made two trips to each medical district during the year and visited secretaries of all county societies, and, in addition, officers, councilors and as many individual members as possible. The councilors and their chairman, Dr. W. McL. Shaw, through these six annual medical district meetings, made it possible for the officers of your Association to personally meet a large portion of the membership. A printed program was sent to every member in each district The six annual meetings were held in the same manner as the Association's annual convention. Full details were published in the Journal and are shown in the annual report of the Council.

The circulation of the Journal has increased steadily and at the present time 1,525 Journals are printed each month The publication of a 1938 Medical Directory for Florida was authorized by the Executive Committee at the time of the Pre-convention meeting in Tampa last January. There were 2,500 copies printed and there are less than 50 left. Every mail for weeks has included orders for five or more Directories. The orders are arriving from registered drug stores, lawyers, insurance companies, funeral directors and advertisers in the Journal. The State Board of Health purchased at a discount of 50%, enough copies for all licensed doctors who are not members of the Association. It is quite possible that a second run of this Directory will have to be printed.

During the year 4,241 letters and 1,559 other pieces of mail were received. Going out from your office were 14,723 letters, over 2,000 Medical Directories and 1,991 packages; and 23,326 sheets were mimeographed.

On November 19 and 20 your managing director attended the meetings of the secretaries of state medical societies and editors of medical journals at the headquarters of the A. M. A. in Chicago. His expensese were paid by the A. M. A. Considerable valuable information was gleaned at these two meetings by personal contact with officers from other state medical societies, as well as by visiting the various departments of the A. M. A. and from a special meeting the last day, of business managers, in making plans for increasing advertisements in the Journal. Mr. Will C. Braun, business manager of the A. M. A. presided at this meeting.

It is not possible in the brief time allotted for this report, to adequately outline and explain the work and plans carried on at your headquarters office. We feel that there has been more accomplished during the past year for the doctors in Florida than in any previous year. The present membership is 1,236, as shown on exhibit "D", and represents the highest membership record for any year in the history of organized medicine in Florida.

The books and records of the Association are open to our members and we will be glad to answer inquiries of any nature. The books have been audited by Ford and Colley and a certification thereof is incorporated in the statements which follow.

Respectfully submitted,

SHALER RICHARDSON, M. D.

STEWART THOMPSON, D. P. H.

FORD & COLLEY
Certified Public Accountants

Jacksonville, Fla., May 5, 1938.

Dr. Shaler A. Richardson,
Treasurer,
Florida Medical Association, Inc.
Jacksonville, Florida.

Dear Sir:

We have examined the attached statements of Cash Receipts and Disbursements of Florida Medical Association, Incorporated, for the period begun March 23, 1937, and ended April 20, 1938. These statements have been prepared by Dr. S. G. Thompson, Managing Director of the Association and the Florida Medical Journal and correctly reflect the cash transactions for the period stated as shown by the books of account.

We have checked the additions of the cash record and have compared the disbursements as entered in the cash journal with the cancelled checks returned by the bank. We have checked the recorded collections to the bank deposits. We have reconciled the bank checking account and have obtained the written confirmation of the bank as to the balance at the close of the period. We have checked the general ledger postings and have verified general ledger additions. We have obtained the written confirmations of the banks as to the savings accounts.

As we do not have access to the records of the various County Societies for the purpose of checking the remittances of dues, attention is directed to Exhibit "D", which gives details as to this matter.

Income from Journal advertising was verified substantially by comparison with a statement of contracts with advertisers furnished by you.

The ten United States Bonds, par value $1,000.00 each, were verified by us with the Atlantic National Bank of Jacksonville, Florida.

Yours very truly,
Ford & Colley

CONSOLIDATED CASH STATEMENT

March 23, 1937 through April 20, 1938

Receipts		
Cash in Bank, March 23, 1937		$22,711.36
Dues Collected (Exhibit "D")	$12,185.00	
Earnings from Advertising (Exhibit "E")	4,344.07	
Subscription and Misc. Sale of Jrnl. and Directory	81.30	
Bonus from Cooperative Medical Adv. Bureau	272.50	
Interest on Savings and Investment	695.33	
Reprints — Non-Members	4.38	
Earnings—Technical Exhibits (Exhibit "C")	1,672.75	19,255.33
Total Cash to be Accounted for		$41,966.69
Disbursements		
General Fund Expenses (Exhibit "A")	$ 8,679.35	
Journal and Directory Expenses (Exhibit "B")	8,209.03	
Technical Exhibit Expenses (Exhibit "C")	$407.33	
To Entertaining Society	720.10	1,127.43
Committee Expenses (Exhibit "A")	1,454.22	
Furniture, Fixtures & Equipment	613.88	
Library	50.80	
Federal Tax	9.68	20,144.39
Balance in Bank, April 20, 1938		$21,822.30

EXHIBIT "A"

CASH STATEMENT—GENERAL FUND

March 23, 1937 through April 20, 1938

Receipts		
Cash as per last audit		$21,505.01
Back dues collected (Exhibit "D")	$ 2,785.00	
Current Dues Collected (Exhibit "D")	9,400.00	12,185.00
Interest on Savings and Investment		695.33
From Exhibit Fund		1,751.67
Total Cash to be Accounted for		$36,137.01
Disbursements		
Postage and Supplies	$ 514.18	
Telephone and Telegraph	160.64	
Salaries	6,600.00	
Convention Expense	34.75	
Traveling Expense	619.05	
Legal Counsel	108.33	
Auditing Expense	12.50	
Office Rent	195.00	
Towel Service	16.65	
Messenger Service	7.10	
Bond of Treasurer	18.75	
Express, Freight & Dray	3.90	
Reprints, Constitution and By-Laws	39.70	
Past President's Buttons	26.00	
Repair Furniture, Clean and Repair Typewriters, Adding Machines, etc.	24.25	

Change partition in office	60.00	
Incidental Items	46.27	
Bank Exchange	4.58	
Transportation Expenses A. M. A. Delegates	137.40	
Investigation, Hospitalization Insurance	50.30	8,679.35
Committees:		
Postgraduate Course	15.00	
Legislative	1,208.18	
Executive	16.00	
Public Relations	31.34	
Venereal Disease	.48	
Council	156.26	
Scientific Program	22.61	
Misc. Committee Expense	4.35	1,454.22
Furniture, Fixtures and Equipment		613.88
Library		50.80
Federal Tax		9.68
To Journal and Directory Fund (Cost above Income)		3,506.78 $14,314.71
Cash Balance		$21,822.30

EXHIBIT "B"

CASH STATEMENT—JOURNAL AND DIRECTORY FUND

March 23, 1937 through April 20, 1938

Receipts

As per last audit		$0.00
Earnings from Advertising (Exhibit "E")	$ 4,344.07	
Subscriptions and Misc. Sale of Journal and Directory	81.30	
Bonus from Cooperative Med. Adv. Bureau	272.50	
Reprints — Non-members	4.38	
From General Fund	3,506.78	
To be Accounted for		$ 8,209.03

Disbursements

Postage and Supplies		392.53	
Printing and Plates		4,990.68	
Telephone and Telegraph		85.23	
Salaries		2,601.87	
Auditing Expense		12.50	
Bond of Treasurer		18.75	
Freight and Drayage		33.52	
Messenger Service		5.00	
Binding of Journals		5.60	
Reprints:			
Membership Roster (Feb. 1937 Jrnl.)	47.25		
1938 Med. Direct. Adv.	8.00		
Seaboard Railway Adv. (April 1938 Jrnl.)	6.10	61.35	
Incidental Expense		2.00	8,209.03
Cash Balance			$ 0.00

EXHIBIT "C"

CASH STATEMENT—EXHIBIT FUND

March 23, 1937 through April 20, 1938

Receipts

Cash as per last audit	$ 1,206.35	
Earnings from Technical Exhibits	1,672.75	
Total Cash to be Accounted for		$ 2,879.10

Disbursements

Postage and Supplies	$ 22.53		
Telephone and Telegraph	9.19		
Convention Expense	251.78		
Floor Plan and Electrotype	27.23		
Sign Painting, etc.	75.50		
Printing	6.10		
Incidental	15.00	407.33	
To Entertaining Society:			
Pinellas County Med. Soc.	153.00		
Dade County. Med. Soc.	567.10	720.10	
		1,127.43	
To General Fund		1,751.67	2,879.10
Cash Balance			$ 0.00

EXHIBIT "E"

EARNINGS FROM ADVERTISING

March 23, 1937 through April 20, 1938

April, 1937	$ 426.74
May	304.14
June	269.16
July	278.52
August	256.33
September	247.12
October	302.95
November	287.20
December	339.48
January, 1938	317.18
February	548.38
March	405.86
April	361.01
Total	$4,344.07

ASSETS AND LIABILITIES

April 20, 1938

Assets

Cash in Bank	$ 9,069.59
General Fund—Accounts Receivable	2,610.00
Journal—Accounts Receivable	409.60
Furniture and Fixtures (less depreciation)	821.45
Library	537.05
Stationery Inventory	159.12
Savings: Atlantic National Bank	4,162.55
Barnett National Bank	8,590.16
Investment (Treasury Bonds)	10,178.13
	$36,537.65

Liabilities

Capital Account	$36,537.65

EXHIBIT "D"

Dues Collected March 23, 1937 Through April 20, 1938

Name of Society	Total Members	No. Paid Members	No. in Arrears	1938 Dues Collected	Back Dues Collected
Alachua	25	17	8	$ 160.00	$ 60.00
Bay	11	9	2	70.00	10.00
Brevard	12	12	0	110.00	60.00
Broward	31	31	0	300.00	20.00
Columbia	15	12	3	110.00	60.00
Dade	278	188	90	1,870.00	1,040.00
DeSoto-Hardee-Highlands	18	16	2	150.00	
Duval	159	134	25	1,330.00	445.00
Escambia	41	33	8	310.00	130.00
Hillsborough	105	81	24	800.00	110.00
Individuals	4	0	4		
Jackson	15	11	4	100.00	10.00
Lake	16	15	1	140.00	20.00
Lee	13	11	2	100.00	40.00
Leon-Gadsden-Liberty-Wakulla-Jefferson	37	16	21	150.00	60.00
Madison	4	3	1	20.00	
Manatee	13	12	1	110.00	10.00
Marion	21	19	2	180.00	10.00
Monroe	3	0	3		
Orange	70	66	4	650.00	80.00
Palm Beach	55	39	16	380.00	60.00
Pasco-Hernando-Citrus	14	12	2	110.00	30.00
Pinellas	87	86	1	840.00	110.00
Polk	61	39	22	380.00	190.00
Putnam	10	8	2	70.00	10.00
St. Johns	10	10	0	90.00	10.00
St. Lucie-Okeechobee-Indian River-Martin	14	14	0	130.00	10.00
Sarasota	15	12	3	110.00	60.00
Seminole	13	13	0	120.00	
Sumter	5	5	0	40.00	10.00
Taylor	8	6	2	50.00	10.00
Volusia	39	31	8	300.00	60.00
Walton-Okaloosa	6	6	0	50.00	
Washington-Holmes	8	8	0	70.00	60.00
Totals	1,236	975	261	$9,400.00	$ 2,785.00
				$2,785.00	Back dues coll.
				$12,185.00	Total dues coll.

Doctor Palmer:

"How much money have they invested, how much in bonds and stocks?"

Doctor Richardson, at the request of Doctor Jelks, read the consolidated cash statement.

On motion duly seconded and carried the report as read was adopted unanimously.

Report of the Executive Committee read by Chairman, Doctor Osincup, as follows:

REPORT OF EXECUTIVE COMMITTEE

To the President and Members of the Florida Medical Association in Session at Miami May 10, 1938.

The first meeting of the Executive Committee was held Wednesday, April 7, 1937 in the Vinoy Park Hotel, St. Petersburg at 2 p. m. Action was taken to follow the present budget setup until the next meeting of the Committee. Action was taken also to authorize the managing director who is to assist the officers of the Association, to allot his time and activities by approval of the Association's secretary. Dr. J. C. Vinson met with the Committee, representing the Committee on Medical Economics and proposed to set up a bureau for investigating indigents and budgeting as an experiment in one county with funds furnished by some philanthropic organization; and that this experiment would not place any financial obligation on the Florida Medical Association; that the setup and enlargement of this experiment for the one county in question would be presented to the Executive Committee for approval from time to time; and that at the end of the year his committee would have material for a comprehensive report by which the plan could be presented with a view to deciding on its merits. The committee approved Doctor Vinson's proposal.

The second meeting of the Executive Committee was held in Orlando, June 24, 1937 at the Angebilt Hotel at 1:30 p. m. President Jelks moved that the following section be recommended to the House of Delegates as an addition to the by-laws. The motion was seconded and carried:

Chapter VIII—Section 1—Add the following after the word "Journal." in line 5:

Any new or reinstated member accepted into the State Association shall be required to pay an entrance fee of $10.00 in addition to his first year's dues. (To become effective January 1, 1939).

A working budget for the fiscal year was adopted. A resolution was adopted by your committee, stating the Association's unequivocal opposition and its unwillingness to cooperate in any plan that involves federal supervision and control of medical practice in the United States. This resolution was mailed to the secretaries of all state societies and to Congressional representatives in Washington and was published in the July, 1937 Journal.

Upon written recommendation of the officers of the Dade County Medical Society, May 9, 10 and 11, 1938 was set as the official time for the annual meeting of the Association, to be held in Miami.

On November 28, 1937 your Executive Committee passed a resolution for guidance in aswering inquiries regarding the attitude of the Association concerning hospital insurance policies. The resolution adopted by your committee was published in the January, 1938 Journal, page 399.

Your committee again met on January 16, 1938 at the Hillsboro Hotel in Tampa. Invitations for the next annual meeting of the State Association were received from the Volusia County Medical Society at Daytona Beach and the Orange County Medical Society at Orlando. Your committee recommends that the 1939 annual meeting be held in Daytona Beach, at the invitation of the Volusia County Medical Society. A representative of the Scientific Program Committee appeared before your committee and a schedule of the program for the Miami meeting was adopted. Your committee, on recommendation of Doctor Richardson, the secretary, authorized the publication annually of a Medical Directory for Florida. Since annual dues or assessments to the State Association are payable January 1 of each year, it was decided, on motion, to drop the names from membership of all doctors who have not paid their dues by December 31 of the current year. On applications duly filed by representative county medical societies, the following doctors were elected to Life Membership in the State Association:

William P. Adamson, Tampa
Albert H. Freeman, Ocala
Hubbard Gates, Bradenton

and the following to Honorary Membership:

Allen H. Miller, Millville
Thomas B. Echard, St. Petersburg.

At the various meetings of your committee, many routine matters were handled, which appear in full in the official minutes on file. This report does not include such items, as there is not time for such a long report to be read. The cost of printing long reports containing routine details is an unnecessary printing expense against the Journal.

Respectfully submitted,
GILBERT S. OSINCUP, Chairman
WILLIAM M. DAVIS
HENRY E. PALMER
E. T. SELLERS
JOSEPH S. STEWART
WILLIAM C. THOMAS
EDWARD JELKS
SHALER RICHARDSON

Motion to adopt the Executive Committee's report as read, unanimously carried.

Motion by Dr. T. A. Neal of Orlando that a rising vote of appreciation be accorded the President and to the Committees for the good work which they have done throughout the year.

Motion duly seconded and carried. Rising vote.

Doctor Jelks:

"I do appreciate this gorgeous expression of your appreciation and I want to say this: that if there ever was a year when the man who was in the highest office that any group could give him had the cooperation and had the effort of every member exerted to the limit, this year I was that man. The members of the Florida Medical Association certainly have taken an active part in everything your officers thought was good for the Association."

There being no further business to come before the meeting, it was moved, seconded and carried that the meeting adjourn.

THIRD SCIENTIFIC ASSEMBLY

The Third Scientific Assembly was held Tuesday, May 10, at 2:00 p. m., Dr. H. E. White presiding.

The following papers were read and discussed:

"Diagnosis and Treatment of Amebic Dysentery", Dr. James L. Borland, Jacksonville.

"Presacral Nerve Resection for the Relief of Pelvic Pain" (motion pictures), Dr. John R. Boling, Tampa.

"Disturbances of Cardiac Rhythm" (lantern slides), Dr. S. Marion Salley, Miami.

"Prefrontal Lobotomy for Involutional Melancholia" (lantern slides), Dr. J. G. Lyerly, Jacksonville.

"The Final Responsibility of Public Health Rests on the Medical Profession", Dr. B. A. McCreary, Jacksonville.

SECOND MEETING OF THE HOUSE OF DELEGATES

The second meeting of the House of Delegates convened at 5:00 p. m., May 10, 1938, in the Bahama Room of the Columbus Hotel, Miami, Florida. President Jelks presided.

The following delegates answered roll-call:

DELEGATES

Brevard County Medical Society:
T. C. Kenaston

Broward County Medical Society:
G. S. McClellan
L. F. Robinson

Columbia County Medical Society:
H. S. Howell

Dade County Medical Society:
J. S. Stewart
Walter Jones
Homer Pearson
Scheffel Wright
Duncan Owens
Herman Boughton
Marion Salley
H. A. Walker
C. G. Mentzer

DeSoto-Hardee-Highlands County Medical Society:
L. W. Martin

Duval County Medical Society:
J. Lunsford Boone
L. Y. Dyrenforth
F. J. Waas
H. B. McEuen
W. McL. Shaw
G. H. Ira

Escambia County Medical Society:
J. M. Hoffman
J. S. Turberville

Hillsborough County Medical Society:
W. C. Blake

Lee County Medical Society:
H. J. Stipe

Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society:
J. H. Pound
B. A. Wilkinson

Marion County Medical Society:
E. G. Peek

Orange County Medical Society:
Horace A. Day
J. R. Chappell
Hewitt Johnston

Palm Beach County Medical Society:
F. K. Herpel
V. M. Johnson

Pasco-Hernando-Citrus County Medical Society:
W. W. Jones

Pinellas County Medical Society:
W. M. Davis
A. J. Wood
W. C. McConnell
O. O. Feaster

Polk County Medical Society:
Geo. Carefoot
R. L. Cline

St. Lucie-Okeechobee-Indian River-Martin County Medical Society:
H. D. Clark

Seminole County Medical Society:
A. W. Knox

Volusia County Medical Society:
J. R. Wells

The recommendation of the Executive Committee read at the first meeting of the House of Delegates relative to the payment of a registration fee was again read as follows and presented for consideration:

Suggested Addition to By-Laws—Chapter VIII, Section 1:

Add the following after word "Journal", in line 5:

Any new or reinstated member accepted into the State Association shall be required to pay a $10.00 Entrance Fee in addition to his first year's dues of $10.00. (To become effective January 1, 1939).

Amendment again read to the effect that this apply except where new members are coming into the Association who have never practiced medicine before. To make it more specific—this assessment shall apply to only those applicants who have completed their original interneship in the hospital not more than 18 months prior to making application.

No discussion. The above amendment voted and lost.

On motion duly made and seconded the above recommendation of the Executive Committee was voted and adopted.

As the next order of business the resolution presented by Doctor Boling at the first meeting of the House of Delegates and revised by Doctor Day was read as follows:

Resolved that Chapter VII of the By-Laws be amended to include a section providing for a General Advisory Board of Past Presidents. That the number of Section 20 be changed to Section 21, and Section 21 be changed to Section 22. That Section 20 shall provide for what shall hereafter be known as the General Advisory Board of Past Presidents. All past presidents automatically become members of this Board. A special seating place for them in a group shall be provided at all sessions of the House of Delegates, and they shall have the privilege of discussing any issue arising therein; but, they shall not have the power to vote on any question. They may be called upon by any committee to act in an advisory capacity, and are urged to render advice to the best of their ability. A meeting of the General Advisory Board of Past Presidents shall be held the opening day of each Annual Convention, after the first session of the House of Delegates, the purpose of which will be to discuss problems of the Association, make recommendations, and select not more than two of its members to present their recommendations to the House of Delegates at the following session, and elect its Chairman, Vice Chairman, and Secretary for the ensuing year.

Doctor Jelks:

"It was mentioned at the first meeting that they should be limited as to the number who spoke. They were to select their spokesman to state whatever they decided to bring up, to present their arguments on that issue."

Suggestion that privileges of the floor be given to one or two members of the Board of Past Presidents to discuss issues.

Doctor Jelks:

"A special seating place for them in a group, shall be provided at all sessions of the House of Delegates and through their spokesman they shall have the privilege or discussing any issue arising therein."

Doctor Ross:

"As one of the members of the Past Presidents' Board, we do not ask for any special seating place. All we desire is to take under consideration those things which they present to the first meeting of the House of Delegates, take our vote on it and present the views of the past presidents on these things which are brought before the first meeting of the House of Delegates. We do not desire any special seating."

Doctor Jelks:

"I don't know of any organization that does not extend the privileges of the floor to its past officers."

Doctor Day:

"As I understand it this is an organization of past presidents. This organization is allowed to discuss issues. I think the past presidents are the best stabilizing influence the Association has. And I think we should allow them to discuss anything pertaining to the State Medical Association."

Doctor Spiers:

"I have observed on a few occasions in the past where it was more or less embarrassing to some of the past presidents to have to be allowed to talk before the House of Delegates. In the first place it had to be voted on before they were allowed that privilege. That was the purpose of this suggestion by several of the past officers. We think they should have this privilege. There are never more than eight or ten present and they do not abuse that privilege. They should be allowed that privilege without the House of Delegates being forced to vote on it. If there is any group of men in the Association which is capable of advising it, certainly that group is the Past Presidents' Board. I think this should go just like it is, that the past presidents be allowed the privileges of the floor. They don't care about the right to vote. However, they are all still interested in organized medicine in Florida, and for that reason they have formed this Past Presidents' Board."

Doctor Richardson:

"I agree with Dr. Spiers on this for the reason that certainly we want to accord the

past presidents this privilege. In the past we have never denied the privileges of the floor to any member of this Association. If any member of the Association wants to bring up any matter at the meeting of the House of Delegates, the House of Delegates always voted for that member to have the privileges of the floor. This states that at the first meeting of the House of Delegates they will have that privilege just as any other member may be accorded that privilege by the House of Delegates. At the second meeting as it is worded it provides that two members of the Association of Past Presidents will have the privileges of the floor, one to represent the majority and one to represent the minority, to present the views of the past presidents and to express their opinions.

I think it should stand as it is."

On motion duly seconded and carried the above resolution was unanimously adopted as read.

The next order of business was reconsideration of a resolution entitled "The Relation of Physicians and Hospitals", as follows:

THE RELATION OF PHYSICIANS AND HOSPITALS

At this time, when the medical profession is so much concerned with hospitals and insurance companies attempting to take over various phases of the practice of medicine, the Committee on Medical Education and Hospitals of the Florida State Medical Association moves the adoption of the following principles governing the relation of physicians and hospitals.

A. Community hospitals are civic enterprises, having a primary charitable motive, undertaken by philanthropic laymen who assume the financial obligation of providing place, equipment and personnel, and by philanthropic physicians who assume the obligation of providing medical care. Such a hospital is a joint enterprise to render aid to ill, indigent persons; the lay supporters contributing time and money as such, the medical supporters contributing time and money in the form of professional service.

B. In order to provide hospitalization for the nonindigent such hospitals customarily maintain accommodation for the care of full-pay patients, as well as for the care of partial-pay patients, who pay for this service according to their ability.

C. In any of these types of hospitalization, however, the hospital as a corporation provides room, board, nursing and material, beyond which it has nothing to dispose of; at this point the medical staff enters the equation as the essential element to make the service of the hospital whole and effective.

D. The staff physicians' services are essential to the charitable purpose of the hospital and the acceptance of his appointment has a certain contract implication, viz., to perform gratuitously the professional service to make effective the hospitalization afforded gratuitously by the institution. A correlative implication of the contract should be that if the institution is recompensed for its service to the patient, the physician should be entitled to recompense in the same proportion, for if the hospital owes it to the supporting public to make the load of charity as light as possible, it owes the same duty to its supporting staff. Otherwise the effect is that the lay supporters of the hospital are relieved of part of their burden, whereas the medical supporters bear the entire burden of their contribution.

E. This contribution to the hospital enterprise is not offset by any advantage offered by the hospital connection to the staff physician. . . If it be said that the hospital lends prestige to the staff, it is much more true that the prestige of the hospital depends upon that of its staff.

F. Hospitals should be made to realize that the profession, through its central organization, the American Medical Association, has evolved certain principles of medical ethics, outlining the duties of physicians to each other, to the profession at large and to the general public; that this code is the evolution of hundreds of years' experience being based on principles that are primarily for the good of the public in order that the profession can serve it most effectively. Since the profession itself is bound by these principles, hospital boards should study them carefully in order to better realize the physicians' viewpoint. This should enable hospitals to correlate their services more adequately to cooperate with the profession to render better service to the public. One section of the principles of medical ethics with which many hospital boards are apparently unacquainted states (Article 6, Section 4):

"It is unprofessional for a physician to dispose of his professional attainment or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is againt sound public policy."

G. Hospitals being corporations, their management and policies are the proper prerogatives of their boards of directors. The organization of such boards commonly has overlooked the fact that there are two necessary factors to make the institution effective, and the medical staff has usually not been represented. This has occasioned two undesirable results: (1) The appearance of policies prejudicial to the medical profession, because the influence and information obtainable from medical members has not been available; and (2) the development of the idea that the staff members are servants of the institution rather than essential partners.

H. It follows that the medical profession must insist upon proper representation on the boards of hospitals, and must so realize their status as partners, rather than servants, that the rights of the profession shall be protected by such representation.

In view of the above stated principles the following recommendations are made:

1. That no hospital shall be permitted to engage in any form of contract practice with an individual, or group of individuals, for any purpose other than that of pure hospitalization.

2. That no hospital shall offer, for a price, any medical service.

3. That in no case may a hospital charge a patient for other than the use of its facilities and material. No medical fee may be charged and retained by the hospital.

4. That emergency and accident cases may have first aid only, administered at the hospital, and the physician selected by the patient must be immediately notified. In no case shall a patient, able to pay, be admitted to the service of a staff member without the request of the patient's own physician, if there be one.

5. That patients who are covered by compensation, health or accident insurance, cannot be considered as indigent.

6. That none but strictly indigent patients shall be admitted to dispensaries.
7. That no case, except in emergency, shall be admitted to a dispensary without a letter from a physician, local priest or pastor, welfare worker or other reputable citizen, to be followed by adequate investigation by the social worker of the hospital, who shall be able to certify that the patient is known to be indigent.
8. That patients who have been discharged shall not later be re-admitted to a dispensary, without certification that his present condition is the same as on his previous admission.
9. That, as a condition upon which members of the Florida State Medical Association may continue to serve on the staff of a hospital or dispensary the institution shall be approved annually with regard to its fair practices.

LELAND F. CARLTON, M. D., Chairman
JOHN R. CHAPPELL, M. D.
JOHN N. MOORE, M. D.
W. C. PAYNE, M. D.
ROBERT B. MCIVER, M. D.
PAUL B. WELCH, M. D.

Motion for adoption. No discussion. Motion seconded and resolution adopted.

Motion by Doctor Summerlin that each member be assessed $5.00. Motion seconded.

Amendment to above motion: Instead of $5.00 assessment, that the dues be raised $2.50 and that portion be set aside for an emergency fund. Doctor Walter Jones moved that the motion and substitute motion be tabled. Motion seconded and carried.

Dr. George S. McClellan moved that the secretary be instructed to remove from the record all discussion pertaining to the above motion and substitute motion. Motion seconded and carried.

The following resolution was read by Dr. F. J. Waas:

RESOLUTION

Whereas, physicians are not allowed to deduct the cost and the upkeep of white coats used in their offices in the routine practice of medicine and

Whereas, the chief counsel of the Internal Revenue Service of the Treasury Department has ruled in G. C. M. 19662 that "amounts expended by jockeys for purchasing and cleaning riding apparel used solely in the performance of their duties are deductible as business expenses." The apparel referred to consisted of trousers, jockey shirts, riding boots and caps. The ruling pointed out that the apparel in question is especially required by the jockey's business and is used solely in such business. The deduction of the expenditures mentioned as business expenses is therefore held allowable inasmuch as such articles do not appear to be adaptable to general or continued wear to the extent that they may be said to replace the jockey's regular clothing.

And furthermore, in G. C. M. 19790 it is ruled that "amounts expended by baseball players for purchasing uniforms used solely in their business are deductible as business expenses." This conclusion is in line with G. C. M. 19662, *supra,* inasmuch as baseball player's uniforms likewise do not fall in the category of clothing which is adaptable to general or continued wear to the extent that such uniforms may be said to replace regular clothing. The ruling holds that baseball uniforms are analogous to theatrical costumes purchased and used exclusively in the production of a play, for which a deduction is allowable. Therefore,

Be It Resolved that the Florida Medical Association instruct its secretary to appeal to said chief counsel of the Internal Revenue Service of the Treasury Department to rule on the expenditures made by physicians for the purchase and upkeep of white coats used specifically by them in the practice of medicine. Be it further

Resolved that copies of this request for ruling be sent to the senators and congressmen representing the State of Florida in Washington.

Doctor Day:

"This does not only apply to white coats, but to everything that the physician might use in the practice of his profession. It represents expense that the doctor goes to and it should be deducted."

On motion duly seconded and carried, the above resolution was adopted.

The following resolution was read by Doctor Stewart:

Whereas, God in His infinite wisdom has seen fit to remove from our midst the beloved brother of Dr. Arthur H. Weiland, one of our most faithful and active members, and

Whereas, we, the members of the Florida Medical Association in convention assembled, feel deeply the grief and misfortune of our comrade and friend, therefore

Be It Resolved that the Florida Medical Association expresses to Dr. Arthur H. Weiland and his grief-stricken family its sorrow in the passing last Sunday of his brother, Dr. Frank Weiland.

Signed,
W. M. ROWLETT
JOSEPH S. STEWART

It was moved, seconded and carried that the above resolution be sent to Doctor Weiland, and made a part of this record.

There being no further business to come before the meeting, on motion duly seconded and carried, the meeting adjourned.

FOURTH SCIENTIFIC ASSEMBLY

The Fourth Scientific Assembly was held Wednesday, May 11, at 9:00 a. m., Dr. Leigh F. Robinson presiding.

The following papers were read and discussed:

13. "Lupus Erythematosus" (lantern slides), Dr. Lauren Sompayrac, Jacksonville.
14. "Adolescent Turmoil: Agitated Depression with Panic Reaction", Dr. Jess V. Cohn, Hollywood.
15. "Sterility", Dr. C. D. Hoffmann, Orlando.

THIRD GENERAL SESSION

The General Session of the Florida Medical Association reconvened at 11:00 a. m., Wednesday, May 11, 1938, in the Assembly Room of the Columbus Hotel.

President Jelks in the Chair.

Meeting called to order.

The guest speaker, Dr. J. M. T. Finney, Emeritus Professor of Surgery, Johns Hopkins University, Baltimore, was introduced by Doctor Jelks.

Doctor Jelks:

"Today you are going to listen to one of the truly great men in medicine. As long as students study medicine, as long as there is any medical literature, the name of this man will be read. You already know of his achievement in his profession. There is another side to this speaker, however, that some of you have not had the pleasure and inspiration of knowing. A definition once read of a gentleman seems to me to express very well the character of this man: A gentleman is a person with courage, kindness, generosity and a sense of service. We who have had the good fortune of knowing personally this speaker, know that is very characteristic of him.

"You are going to hear an address on the subject of "The Role of the Imponderables in Surgery" by Dr. J. M. T. Finney of Baltimore, Md. Doctor Finney lives in the thoughts of those who know him."

Address, "The Role of the Imponderables in Surgery," by Dr. J. M. T. Finney.*

Doctor Jelks:

"Those of us who are here today will remember for the rest of our time this occasion. I hope it has done something for the man or woman who may have had a suspicion that some day he or she wants to take that despondent position of a desire for death. I think none of us may do that because we will remember, before that state becomes extreme enough for us to back out, what Doctor Finney has told us today. He certainly has given us something to think about in handling our patients. However, we are at a much greater disadvantage than he is because so few of us inherited that fine sense of humor as do those of Irish parentage.

*To be published in July, 1938, Journal.

"This is a great occasion today in the history of the Florida Medical Association, having Doctor Finney here, and we appreciate his coming and delivering to us that lecture."

Doctor Jelks then introduced Dr. T. S. Anderson of Live Oak, a member since 1890, and announced that he had been made a Life Member of the Association.

There was no unfinished or new business to come before the meeting.

The meeting then proceeded to the election of officers.

Doctor Leigh Robinson of Ft. Lauderdale nominated as President-elect by Dr. Gerry Holden. Seconded by Doctor Peek.

Motion by Doctor Barge that the nominations be closed and the Secretary instructed to cast a unanimous ballot for Doctor Robinson.

Motion seconded and carried.

Doctor Robinson was then escorted to the rostrum by Doctor Holden.

Doctor Robinson:

"It always makes me feel dizzy to be elevated to great heights. However, I certainly appreciate this honor and confidence.

"The high standards set by the present and the past presidents of this Association make me feel very small indeed. I can only promise that when the time comes for me to serve you, I will do my very best toward carrying on their good work.

"Thank you, Gentlemen."

Dr. Arthur Weiland, President of the Dade County Medical Society, was nominated for first vice president by Dr. J. C. Davis.

Motion seconded and carried that the nominations be closed and the Secretary instructed to cast a unanimous ballot for Doctor Weiland.

Doctor E. G. Peek was nominated for second vice president by Doctor Barge.

Motion seconded and carried that the nominations be closed and the Secretary instructed to cast a unanimous ballot for Doctor Peek.

Doctor Ralston Wells nominated for third vice president by Doctor Hendricks.

Motion seconded and carried that the nominations be closed and the Secretary instructed to cast a unanimous ballot for Doctor Wells.

Doctor Shaler Richardson was nominated

for Secretary-Treasurer and Editor of the Journal, by Doctor Osincup.

Motion seconded and carried that the nominations be closed and a unanimous ballot be cast for Doctor Richardson.

Doctor Spiers, President-elect, escorted to the chair by Doctor McKinnon.

Doctor Spiers: "I wish to thank the members of the Florida Medical Association for the confidence placed in me, to serve as your president for the ensuing year. Since my election a year ago, every day and every hour I have appreciated more and more, my limitations and have approached the responsibility of serving you as president, with a deep sense of inadequacy. I need the help of every one of you. I am yours to command and desire to help where and whom I can, to hold fast to the traditions of the sound science and sensible practice of medicine in Florida.

"I enlist your enthusiastic participation in organized medicine. If we stand together we can accomplish anything. Divided by silly differences, we are all sure to succumb to practices and policies that would modify the expression of the wonderful medical doctor of tomorrow. He is our responsibility. We will not fail him because our predecessors have paved the way for us. Since 1873 when the Florida Medical Association was organized, there has always been a group of medical doctors in this state who have carried on. Their problems have been as great as ours and, with their facilities for solving them, perhaps greater at times.

"In assuming the duties of president, I will not be less active than I have been in my effort to promote the interests of the Association but will try to justify the confidence implied in my election to this responsible position.

"I like to believe that it is an inherent love of humanity that makes life's goal the universal brotherhood of man. Indeed, it might have been of the "Spirit of Medical Practice" that it was written:

The stars may fade away
The sun himself grow dim with age
And nature sink in years.
But thou shalt flourish in mortal youth
Unhurt amidst the war of elements,
The wreck of matter or crash of worlds.

"May I say again in concluding my remarks that I am grateful for this undeserved honor you have bestowed upon me.

"So here's to you, then, my friends and fellows; here's to your business and here's to your legion; here's to your wealth and your wisdom from one who has neither; here's to your problems and perplexities from one who has both of his own; here's to your trade, which is the making of gifts; to your art which is the creation of happiness; to your traffic, which is a traffic in affections. And here's to this meeting; to its aims and its efforts. May the hearts of our members join in one great friendship; join, weld, amalgamate and fuse together with the same entirety and wholeness with which one atom of matter meets, mingles and joins with another.

"And now you belong to me and I belong to you. I thank you."

Doctor Jelks:

"This official gavel with which to keep order I very gladly turn over to you, Doctor Spiers."

Presentation of a special gavel for Dr. Jelks from Dr. Spiers:

"I have had this gavel made of cypress, one of the oldest forms of tree life in Florida. This gavel was probably in existence at the time of Hippocrates. I present this to you here just as a token because of my sincere feeling for you and our relationship in the past. I hope that you will stick by me during the next year as you promised to do."

Presentation of Past President's button to Doctor Edward Jelks by Doctor Palmer:

"Ed, it is my privilege to present this token of our appreciation to you. It is something that you can keep and hand down to future generations. I want to say that you have fulfilled our greatest expectations and set a record for devotion, success and true living for the medical profession of your adopted State, and I want to tell you that you have won the love and admiration of every member of organized medicine."

Doctor Jelks:

"Mr. President, Doctor Palmer:

"These two presentations I shall keep as mementos of two different things. The one I shall keep as a reminder of the fact that although this terminates a certain position with

this Association, still as long as I shall live it will be my duty and my pleasure to render any assistance possible as a member of the Florida Medical Association. And I promise Doctor Spiers that this last certainly will not be put up where it can't be seen until after he is through with his year's work next year.

"As to the pin, it will be worn with pride as a reminder of the wonderful cooperation that the members of this Association have rendered this year to the officers, and with also a feeling of much stronger affection that the retiring president has for each of you individually than it has been possible in the past for him to feel because he did not know you so well, and he appreciates the opportunity of having known better each one of the members of the Florida Medical Association."

Motion by Doctor Palmer that the Secretary be instructed to return thanks to the Dade County Medical Association, city officials and the management and employees of the Columbus Hotel, and all others who aided in making this meeting one of the most successful of the Association. Seconded by Doctor Robinson. Unanimously carried. Rising vote of appreciation by the assembly.

Announcement by Dr. Spiers that a representative of the Industrial Council would meet with the Executive and Hospital Committees in the Bahama Room immediately following this meeting.

There being no further business to come before the meeting, on motion duly made, seconded and carried, the meeting adjourned, sine die.

REGISTRATION

The total registration during the Sixty-fifth Annual Meeting of the Florida Medical Association, held in Miami, May 9, 10 and 11, was 762; members, 482; visiting doctors, 52; exhibitors, 62; Woman's Auxiliary, 166.

REGISTRATION LIST

Officers

Jelks, Edward, President ..... Jacksonville
Spiers, W. Henry, President-elect ..... Orlando
Marr, Norval M. First Vice-President St. Petersburg
Burch, R. N., Second Vice-President ..... Miami
Richardson, Shaler, Secretary-Treasurer Jacksonville
Thompson, Stewart, Managing Director .. Jacksonville

Alachua County Medical Society

Anderson, James M. ..... Cross City
Andrews, Edwin H. ..... Gainesville
Maines, John E., Jr. ..... Gainesville
Murphree, W. E. ..... Raiford
Preston, H. F. ..... Melrose
Summerlin, J. L. ..... Gainesville
Summitt, R. E. ..... Gainesville
Thomas, W. C. ..... Gainesville
Tillman, G. C. ..... Gainesville

Bay County Medical Society

Adams, D. M., Jr. ..... Panama City

Brevard County Medical Society

Bean, I. F. ..... Melbourne
Benton, George H. ..... Melbourne
Hay, I. M. ..... Melbourne
Kenaston, T. C. ..... Cocoa
Page, Walter C. ..... Cocoa

Broward County Medical Society

Blount, Robert E. ..... Ft. Lauderdale
Brown, Oliver C. ..... Ft. Lauderdale
Butler, Bruce F. ..... Hollywood
Camp, Milton N. ..... Ft. Lauderdale
Cohn, Jess V. ..... Hollywood
Connor, A. B. ..... Ft. Lauderdale
Darrow, Anna A. ..... Ft. Lauderdale
Elliston, Leroy B. ..... Ft. Lauderdale
Elliston, Robert L. ..... Ft. Lauderdale
Farringer, Robert H. ..... Hollywood
Hamner, George P. ..... Hollywood
Hendricks, Elliott M. ..... Ft. Lauderdale
Johnston, John A. ..... Ft. Lauderdale
McClellan, George S. ..... Pompano
McMurray, James W. ..... Ft. Lauderdale
Peavy, Henry J. ..... Ft. Lauderdale
Pierce, Francis D. ..... Ft. Lauderdale
Robinson, Leigh F. ..... Ft. Lauderdale
Sory, Curtis H. ..... Ft. Lauderdale
Stovall, R. H. ..... Ft. Lauderdale
Winsor, Sanford A. ..... Pompano

Columbia County Medical Society

Anderson, Thomas S. ..... Live Oak
Cone, Daniel N. ..... Jacksonville
Howell, Harry S. ..... Lake City

Dade County Medical Society

Adams, Charles C. ..... Miami
Adkins, E. H. ..... Miami Beach
Alberts, Irving L. ..... Miami Beach
Alderson, S. P. ..... Miami
Alexander, Julius ..... Miami
Alexander, Lassar ..... Miami
Allen, Ralph F. ..... Miami
Amerise, A. Daniel ..... Coral Gables
Anderson, James L. ..... Miami
Andrews, Laurin L. ..... Miami
Arango, R. J. ..... Miami
Aronovitz, Samuel ..... Miami
Baker, L. A. ..... Miami
Barge, H. A. ..... Miami
Barge, W. J. ..... Miami
Black, Nelson M. ..... Miami
Boughton, Herman ..... Miami Beach
Branham, John C. ..... Miami Beach
Browne, Van M. ..... Hialeah
Brunner, E. C. ..... Miami
Bullard, Clifton P. ..... Miami
Burbacher, Charles R. ..... Coral Gables
Burch, John E. ..... Coral Gables
Carroll, B. D. ..... Miami
Chambers, Silas E. ..... Miami
Chandler, G. E. ..... Miami
Cleveland, Jack Q. ..... Coral Gables

Conger, George D. ... Miami
Coplan, M. M. ... Miami
Couric, Edmonson S. ... Miami
Cullipher, Edward W. ... Miami
Davis, H. Frank ... Miami
Day, George H. ... Miami
Dees, John ... Miami
Denman, Francis E. ... Miami Beach
DeVilbiss, Lydia A. ... Miami
Dodge, Percy L. ... Miami
Dowlen, Otto S. ... Miami Beach
Dunaway, Carl E. ... Miami
DuPuis, J. G. ... Miami
Eichert, Herbert ... Miami
Elder, Samuel F. ... Miami
Elgin, Lee W. ... Miami Beach
Ellis, William H. ... Miami
Exley, David W. ... Miami
Faver, R. Marshall ... Miami
Fitzgerald, Willard L. ... Miami
Fleming, Richard M. ... Miami
Flipse, M. Jay ... Miami
Folsom, Charles W. ... Miami
Fox, Edward F. ... Miami
Francisco, Gladstone E. ... Miami
French, Bessie S. ... Miami
French, Elmo D. ... Miami
Frobisher, Hamilton B. ... Coral Gables
Gammage, Tom R. ... Miami
Garrard, H. F. ... Miami Beach
Goodson, W. M. ... Miami
Gowdy, Francis A. ... Ft. Pierce
Gowdy, Ralph A. ... Miami Beach
Graves, J. Raymond ... Miami
Grimes, Dewey H. ... Coral Gables
Haggard, William A. ... Miami
Hall, E. J. ... Miami
Hall, John E. ... Miami
Hanna, Fuad H. ... Miami Beach
Harness, A. J. ... Miami Beach
Harris, David W. ... Ft. Lauderdale
Harris, Robert M. ... Miami
Hatch, Ernest B. ... Miami
Heck, Maurice E. ... Miami
Hewlett, Frank W. ... Coral Gables
Hinton, Andrew H. ... Miami
Hobbs, Laura M. ... Miami
Hodsdon, Benjamin F. ... Miami
Hodsdon, L. A. ... Miami
Hotchkiss, W. T. ... Miami Beach
Howell, R. Spencer ... Miami
Hutson, Thomas W. ... Miami
Ingersoll, J. M. ... Miami
Izlar, W. H. ... Miami
Jack, Ralph W. ... Miami
Jeffrey, James R. ... Miami Springs
Jeffrey, S. L. ... Miami
Jenkins, Leslie M. ... Miami
Jenkins, Paul K. ... Miami Beach
Jones, Allan ... Miami Beach
Jones, Walter C., Jr. ... Miami
Keeler, Frank L. ... Miami
Kells, Paul ... Miami
Kennon, Charles L. ... Miami
Kinsey, E. T. ... Miami
Kitchens, F. E. ... Coral Gables
Kugel, Maurice A. ... Miami Beach
Lamar, C. P. ... Miami
Lanier, W. T. ... Miami
Laymon, R. L. ... Miami
Leavitt, H. A. ... Miami
Lefholz, R. ... Miami
Leonard, George N. ... Miami Beach
Levin, Alfred G. ... Miami
Lewis, Taylor ... Miami
Light, S. D. W. ... Miami
Lilly, George D. ... Miami
Lithgow, William D. ... Miami
Litterer, A. Buist ... Miami
Lott, Young C. ... Miami
Lowe, Eugene C. ... Miami
Lucinian, Joseph H. ... Miami
Lustgarten, A. ... Miami Beach
Lyell, Robert O. ... Miami
McCiamroch, James M. ... Miami
Macdonald, John T. ... Miami
MacDonell, George N. ... Miami
McGunagle, J. E. ... Miami
McKenzie, E. N. ... Miami
McKenzie, Jack A. ... Miami
McLemore, Carl S. ... Miami Beach
Manson, Plumer J. ... Miami
Marks, Meyer B. ... Miami Beach
Marsh, Lucille J. ... Miami
Maxwell, Eugene B. ... Miami Beach
Medlin, Willard B. ... Miami
Melvin, Perry D. ... Miami
Mendel, James H. ... Miami
Mentzer, Claude G. ... Miami
Milton, John D. ... Miami
Mitchell, John T. ... Miami
Morrow, Frank R. ... Miami
Navarro, Jose ... Miami
Nichol, E. Sterling ... Miami
Nugent, James J. ... Miami
Nuzum, Russell K. ... Miami
O'Quinn, Leon H. ... Hialeah
Otto, Thomas O. ... Miami
Owens, W. Duncan ... Miami Beach
Pallister, William T. H. ... Miami
Palmer, Bascom H. ... Miami
Panettiere, Cayetano ... Miami Beach
Payton, Frazier J. ... Miami Beach
Pearce, Naboth O. ... Miami Beach
Pearson, H. Colquitt ... Miami
Pearson, Homer L., Jr. ... Miami
Pearson, John R. ... Miami
Pearson, Julius R. ... Miami Beach
Pearson, Nelson T. ... Miami
Pearson, Rufus J. ... Miami
Pepper, Max ... Miami
Perdue, Jean ... Miami Beach
Perdue, J. Randolph ... Miami
Perry, C. Larimore ... Miami
Peters, Edgar ... Miami
Phillips, Kenneth ... Miami
Pomerance, Joseph B. ... Miami Beach
Putman, James H. ... Miami
Quillian, Warren W. ... Coral Gables
Raap, Gerard ... Miami
Ramsey, Russell W. ... Miami
Rand, Harold ... Miami
Rash, Jack O. W. ... Miami
Rentz, Lawson S. ... Miami
Repass, Robert E. ... Miami Beach
Richardson, James C. ... Miami
Richardson, John R. ... Miami Beach
Rinaman, James C. ... Miami
Robbins, Alexander ... Miami Beach
Roberts, S. J. ... Miami
Rogers, Hunter B. ... Miami
Roth, Edward ... Miami Beach
Salley, S. Marion ... Miami
Sams, Wiley M. ... Miami
Sandberg, T. D. ... Coral Gables
Saslaw, Milton S. ... Miami
Scarborough, C. A. ... Miami
Schaeffer, O. A. ... Miami
Shaw, E. Clay ... Miami
Silverman, Harry Z. ... Miami Beach
Skaggs, P. T. ... Miami
Skilling, Francis C. ... Miami
Smith, C. Kirby ... Miami
Smith, Donald W. ... Miami

Smith, Marvin H. ..... Miami
Snyder, John W. ..... Miami
Spicer, Robert T. ..... Miami
Stewart, Franz H. ..... Miami
Stewart, Joseph S. ..... Miami
Stuart, J. D. ..... Miami
Thomas, Efton J. ..... Miami
Thomas, Kelly C. ..... Miami
Thomson, William R. ..... Miami Beach
Thorne, James I. ..... Miami
Threlkeld, Major E. ..... Miami
Travers, M. Paul ..... Miami
Tumlin, Corbett E. ..... Miami
Vinson, W. J. ..... Miami
Vogt, Ferdinand A. ..... Miami
Voris, Frank B. ..... Miami Beach
Walker, Harrison A. ..... Miami Beach
Wallace, Albert W. ..... Miami Beach
Walters, Arthur L. ..... Miami Beach
Weiland, Arthur H. ..... Coral Gables
Weinkle, Barney ..... Miami
Welch, P. B. ..... Miami
Whelchel, Lynn W. ..... Miami
White, D. Ward ..... Miami Beach
Wood, Arthur W. ..... Miami
Woodard, Robert C. ..... Miami
Woods, Frank M. ..... Miami
Wright, Scheffel H. ..... Miami
Youmans, Corren P. ..... Miami
Youmans, Iva C. ..... Miami
Zimmerman, Maurice ..... Miami Beach

DeSoto-Hardee-Highlands County Medical Society

Martin, L. W. ..... Sebring
Peacock, W. H. ..... Wauchula
Poucher, Allen A. ..... Wauchula
Weems, Howard V. ..... Sebring

Duval County Medical Society

Boone, J. Lunsford ..... Jacksonville
Borland, J. L. ..... Jacksonville
Brooks, W. H. ..... Jacksonville
Brown, Alan D. ..... Jacksonville
Cason, Turner Z. ..... Jacksonville
Chapman, Benjamin A. ..... Jacksonville
Dyrenforth, Lucien Y. ..... Jacksonville
Goodale, Banks H. ..... Jacksonville
Greene, Ralph N. ..... Coral Gables
Holden, Gerry R. ..... Jacksonville
Holloway, Luther W. ..... Jacksonville
Hughes, V. A. ..... Jacksonville
Ira, Gordon H. ..... Jacksonville
Kirby-Smith, J. Lee ..... Jacksonville
Laffitte, L. Sydnor ..... Jacksonville
Limbaugh, Louie M. ..... Jacksonville
Lipscomb, T. H. ..... Jacksonville
Logie, Arthur J. ..... Jacksonville
Lovejoy, John F. ..... Jacksonville
Lyerly, J. G. ..... Jacksonville
McCreary, A. B. ..... Jacksonville
McCullagh, William H. ..... Jacksonville
McEuen, H. Bernard ..... Jacksonville
McIver, Robert B. ..... Jacksonville
McPhaul, W. A. ..... Jacksonville
Mabry, C. B. ..... Jacksonville
Manning, William S. ..... Jacksonville
Richards, Ferdinand ..... Jacksonville
Richardson, George W. ..... Jacksonville
Ross, William E. ..... Jacksonville
Shaw, W. McL. ..... Jacksonville
Sompayrac, Lauren M. ..... Jacksonville
Swift, Edwin C. ..... Jacksonville
Taylor, H. Marshall ..... Jacksonville
Thomas, R. Y. H., Jr. ..... Jacksonville
Van Shaick, Harold D. ..... Jacksonville
Waas, F. J. ..... Jacksonville
Washburn, Clayton D. ..... Jacksonville
Woolsey, Bertram F. ..... Jacksonville

Escambia County Medical Society

Born, Charles A. ..... Pensacola
Bryans, Herbert L. ..... Pensacola
Hoffman, James M. ..... Pensacola
Lischkoff, Mozart A. ..... Pensacola
McLane, J. N. ..... Pensacola
Payne, W. C. ..... Pensacola
Turberville, J. K. ..... Century
Turberville, John S. ..... Century

Hillsborough County Medical Society

Adamo, Frank S. ..... Tampa
Adamson, William P. ..... Tampa
Bidwell, Alfred M. ..... Tampa
Blackmon, H. J. ..... Tampa
Blake, W. C. ..... Tampa
Boling, John R. ..... Tampa
Bottari, Giulio C. ..... Tampa
Brown, Harold O. ..... Tampa
Carlton, Leland F. ..... Tampa
Dickinson, J. C. ..... Tampa
Duke, R. R. ..... Tampa
Estes, James L. ..... Tampa
Gilbert, Elsie M. ..... Tampa
Gilmer, Eugene S. ..... Tampa
Guerra, Julio J. ..... Tampa
Helms, John S., Jr. ..... Tampa
Lancaster, William J. ..... Wilmington, N. C.
Lowry, Blackburn W. ..... Tampa
McEachern, J. R. ..... Tampa
Martin, Douglas D. ..... Tampa
Moore, John T. ..... Tampa
Nelson, Robert G. ..... Tampa
Rowlett, W. M. ..... Tampa
Rudisill, C. A. ..... Tampa
Smith, Burdette ..... Tampa
Smith, H. Mason ..... Tampa
Spoto, Joseph S. ..... Tampa
Taylor, Joseph W. ..... Tampa
Torbett, Ralph S. ..... Tampa
Vinson, J. C. ..... Tampa

Jackson County Medical Society

Baltzell, N. A. ..... Marianna
Chappell, F. V. ..... Jacksonville
McKinnon, Daniel A. ..... Marianna

Lake County Medical Society

O'Kelley, Marion B. ..... Leesburg
Tyre, C. McK. ..... Eustis

Lee County Medical Society

Bostelman, Ernest ..... Ft. Myers
Jones, H. Quillian ..... Ft. Myers
Stipe, Harvie J. ..... Ft. Myers

Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society

Davis, Julius C. ..... Quincy
Johnston, J. Kent ..... Tallahassee
Palmer, Henry E. ..... Tallahassee
Pound, J. H. ..... Tallahassee
Stevens, Ralph E. ..... Chattahoochee
Wilhoit, Sterling E. ..... Quincy
Wilkinson, B. A. ..... Tallahassee

Manatee County Medical Society

Blake, Lowrie W. ..... Bradenton
Harrison, M. M. ..... Bradenton
Larrabee, Charles W. ..... Bradenton
Sugg, William D. ..... Bradenton

Marion County Medical Society

Dozier, Henry C. ..... Ocala
Lytle, Carl S. ..... Dunnellon
Mimms, Carney W. ..... Ocala
Moore, J. N. ..... Ocala
Peek, Eugene G. ..... Ocala
Russell, Ralph E. ..... Ocala
Wallis, Thomas H. ..... Ocala

Orange County Medical Society

Beardall, Harold M. Orlando
Brame, Dorothy D. Orlando
Chappell, John R. Orlando
Christensen, Louis N. Orlando
Day, Horace A. Orlando
Folsom, Spencer A. Orlando
Gray, Frank D. Orlando
Hart, Ruth S. Winter Park
Henderson, R. P. Orlando
Ingram, Hollis C. Orlando
Ingram, L. C. Orlando
Jewett, Eugene L. Orlando
Johnston, Hewitt Orlando
McBride, Thomas E. Apopka
McEwan, Duncan T. Orlando
Mallory, Meredith Orlando
Neal, Thomas A. Orlando
Orr, Louis M., II Orlando
Osincup, Gilbert S. Orlando
Page, W. Grady Orlando
Rivers, Thomas M. Kissimmee
Pines, John A. Orlando
Sutter, Leroy M. Orlando
Thompson, Rollin D. Orlando

Palm Beach County Medical Society

Arnold, Wilbur O. West Palm Beach
Baldwin, R. Henry West Palm Beach
Blair, Wm. M. West Palm Beach
Carlisle, J. L. West Palm Beach
Creel, Charles E. Pahokee
Davis, Kenneth McC. Delray Beach
Dawson, George M. West Palm Beach
Fleming, Ward West Palm Beach
George, W. W. West Palm Beach
Heath, Guy W. West Palm Beach
Herpel, Frederick K. West Palm Beach
Johnson, Vesey M. West Palm Beach
Lewis, Gaylord West Palm Beach
Miller, Alice R. West Palm Beach
Montgomery, Kenneth West Palm Beach
Netto, Lloyd J. West Palm Beach
Newnham, J. A. West Palm Beach
Nowling, James C. West Palm Beach
Papot, Grace E. West Palm Beach
Pittman, J. H. West Palm Beach
Rozier, Lauchlin M. West Palm Beach
Sayad, William Y. West Palm Beach
Schiffli, O. F. Clewiston
Shackelford, C. W. West Palm Beach
Shackelford, W. L. West Palm Beach
Sory, B. B. Jr. Palm Beach
Sory, James R. West Palm Beach
Stone, Vale D. West Palm Beach
Van Landingham, William E. West Palm Beach
Wakefield, Harry A. West Palm Beach
Weems, William H. West Palm Beach

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Harvard, S. C. Brooksville
Jones, W. Wardlaw Dade City
Walters, William H., Jr. Lacoochee

Pinellas County Medical Society

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Bieker, Arthur J., Jr. St. Petersburg
Davis, William M. St. Petersburg
Dawson, S. A. St. Petersburg
Feaster, O. O. St. Petersburg
Frederick, A. R. St. Petersburg
Gable, Linwood M. St. Petersburg
Herring, John A. St. Petersburg
Knowlton, R. H. St. Petersburg
LeBreton, Prescott St. Petersburg
McConnell, Whitman C. St. Petersburg
Mills, A. L. St. Petersburg
Nelson, Orville N. Bay Pines
Nickle, M. A. Clearwater
Owen, R. W. S. St. Petersburg
Quicksall, J. Braden St. Petersburg
Thurston, Leon St. Petersburg
Wade, Hugh W. St. Petersburg
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Boulware, James R., Jr. Lakeland
Carefoot, G. H. Ft. Meade
Cline, R. L. Lakeland
Lester, John G. Lakeland
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Coleman, Benjamin Miami
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Crossley, E. R. Miami
Daly, Thomas E. West Palm Beach
Davis, Claude L. Alma, Ga.
Davison, T. C. Atlanta, Ga.
Dowlen, L. W. Miami
Draper, Warren F. Washington, D. C.
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Epperson, Roy W. Athens, Tenn.
Farringer, H. R. Miami
Finney, J. H. Miami
Finney, J. M. T. Baltimore, Md.

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Hampton, Adele ..... Miami
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Hatch, John A. ..... Penn Yan, N. Y.
Holm, P. F. ..... Wells, Minn.
Jones, Glenn I. ..... Washington, D. C.
Kauders, Ferdinand H. ..... Miami
Keiser, Robert ..... Miami
Kelk, John A. ..... Miami
Kemp, Simon I. ..... Jacksonville
Kuhnert, Tom H. ..... Miami
LeDrew, Frederick ..... Miami
Lively, William M. ..... Miami
Loranz, C. P. ..... Birmingham, Ala.
McMullen, D. B. ..... Port St. Joe
Mapother, Paul ..... Miami
Morehouse, J. W. (S. B. H.) ..... Jacksonville
Morgan, Charles R. ..... Miami
Ormsby, W. B. ..... Chicago, Ill.
Parke, William E. ..... Miami
Patterson, James N. ..... Jacksonville
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Seff, Isadore ..... Miami Beach
Snyder, Frank L. ..... Miami
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Whitmer, Kenneth S. ..... Miami
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Woodworth, G. A. ..... Niles, Ohio
Zborowski, Thomas S. ..... Jacksonville
Zinn, Francis T. ..... Key West

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Campbell, Allan, Surgical Supply Company ..... Orlando
Carter, J. M., Petrolagar Laboratories, Inc. ..... Sarasota
Casey, Allen M., Wm. S. Merrell Company ..... Tampa
Cuthbert, Guy E., Surgical Supply Company ..... Tampa
Darden, Henry R., E. R. Squibb & Sons, New York
Davis, Bill, Southeastern Optical Company ..... Tampa
DeBardelaben, J., Lederle Laboratories, Atlanta, Ga.
Dulany, Harry G., Surgical Supply Co., Jacksonville
Fassett, L. W., White Belt Dairy Laboratories ..... Miami
Gilmore, J. H., Mead Johnson & Co. ..... Atlanta, Ga.
Hansen, R. E., Philip Morris, Queens Village, N. Y.
Haynes, Ira J., American Medical Assn. ..... Homestead
Heether, Hans B., Keleket X-Ray Co., Jacksonville
Heether, Mrs. H. B., Keleket X-Ray Co., Jacksonville
Hirsch, E. S., Southeastern Optical Company ..... Miami
Horton, H. E., General Electric X-Ray Corp., Tampa
Ingalls, Miss Guilda, Philip Morris & Company ..... Miami
Jensen, P. A., Westinghouse X-Ray Company ..... Atlanta
Jongedyk, P., General Electric X-Ray Corp., Miami
Knowles, Mrs. Kathleen, Jones Metabolism Co., Miami
Laux, J. D., American Medical Assn. ..... Chicago, Ill.
Lester, O. D., Lederle Laboratories, Inc. ..... Jacksonville
Lindley, J. E., E. R. Squibb & Sons ..... Miami
McEnany, Ed. J., A. S. Aloe Company ..... Coral Gables
McEnany, Thomas J., A. S. Aloe Co. ..... Coral Gables
Mackel, S. C., Genl. Electric X-Ray Corp., Jacksonville
Merrihew, James S., Jones Metabolism Co. ..... Miami
Miller, D. L., A. S. Aloe Company ..... St. Louis, Mo.
Mills, Dr. C. F., H. G. Fischer Company ..... Miami
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Nelson, A. C., Westinghouse X-Ray Company ..... Miami
Nichelson, H. B., American Optical Company ..... Miami
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Pynchon, Mrs. May, Fla. T. B. & H. Assn., Jacksonville
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Reisman, J. N., Surgical Selling Co. ..... Atlanta, Ga.
Reisman, Mrs. J. N., Surgical Selling Co., Atlanta, Ga.
Rezeau, Shirley, Philip Morris & Company ..... Miami
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Shikany, G. P., Surgical Selling Company ..... Miami
Shikany, Mrs. Ila L., Surgical Selling Company ..... Miami
Shikany, S. A., Surgical Selling Company ..... Miami
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Spitze, Harold, Genl. Elec. X-Ray Corp., Atlanta, Ga.
Swanson, Charles, Pet Milk Company ..... St. Louis, Mo.
Terry, G. I., C. V. Mosby Company ..... St. Louis, Mo.
Thomas, A. D., DuPont Film Mfg. Co., Atlanta, Ga.
Thomas, O. F., Pet Milk Company ..... St. Louis, Mo.
Thompson, A. F., H. G. Fischer Company ..... Tampa
Thompson, Raymond H., Surgical Supply Co., Miami
Tracy, D. O., Pet Milk Company ..... St. Louis, Mo.
Wallwork, N., Bard-Parker Company ..... Miami
Weaver, M. H., American Optical Co. ..... Jacksonville
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Wilson, George, Surgical Selling Company ..... Miami

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(Terms expire after A.M.A. meeting, 1939)

(Address all communications to Box 1018, Jacksonville)



W. HENRY SPIERS, OUR PRESIDENT

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OUR PRESIDENT

Dr. W. Henry Spiers of Orlando, has long been prominent in organized medicine, having served on many important committees and having held the vice presidency of the Florida Medical Association. He therefore comes to his post well qualified to face the many complex problems attaching to the position of president.

Doctor Spiers was born in Jacksonville on February 5, 1885, where he received his preliminary education. He entered the Florida Agricultural College, Lake City, in the fall of 1901 and the following year he attended the East Florida Seminary at Gainesville, where he continued his studies for three years. In 1904 he entered the Atlanta School of Physicians and Surgeons (later Emory University) but was forced to leave at the end of his junior year, in 1907. He re-entered this College in 1912 and received his M.D. degree in 1914.

Following his graduation, Doctor Spiers returned to Florida where he began the practice of his profession in Bronson, Levy County. In 1916 he was appointed an assistant physician at the State Hospital at Chattahoochee, which position he held until he entered the Medical Corps of the United States Army, as first lieutenant, in 1918. While in the Service he was a member of the examining board at the embarkation and debarkation center at Le Mans, France.

After the war, Doctor Spiers returned to his position at the State Hospital and in October, 1920 was made clinical director of the institution. He resigned this position the following year to enter private practice in Orlando.

Doctor Spiers and Miss Maybelle Kennedy of Jacksonville were married on March 10, 1908. They have two sons, William Henry, Jr., and James Kennedy.

ASSOCIATION'S ANNUAL MEETING

The Miami convention which was the Association's Sixty-fifth Annual Meeting, was a decided success and will long be remembered as one of the greatest occasions of its kind in the state. In numbers it surpassed all previous records, with a total registration of 762. Of that number, 482 were members of the State Association, 52 were visiting doctors, 166 were members and guests of the Woman's Auxiliary, and 62 were representatives of exhibiting firms. The Dade County Medical Society, through its officers and members, were untiring in making preparations for this annual meeting, as well as in looking after arrangements during the entire convention. This entertaining society is noted for its active membership and, as a demonstration, registered 212 local doctors who were members of the Dade County Medical Society. This registration of a local society is a record that will undoubtedly stand unchallenged for many years.

One new feature of the convention was the decision of the Executive Committee to schedule the first meeting of the House of Delegates Monday morning. The entire forenoon was devoted to the deliberations which confront the first meeting of the House of Delegates. Heretofore, the first meeting of the House of Delegates was scheduled Monday evening, which was inconvenient for the 57 delegates and the officers who are required to attend. More and more work has been assigned to the House of Delegates making it advisable to arrange a schedule for this meeting which would provide

ample time for consideration of the problems presented.

In addition to committee reports and other routine business, two changes were made in the by-laws, which will be of particular interest to all members of the Association. First, all new members joining the State Association and all former members who are reinstated will be required to pay an entrance fee of $10.00, in addition to the first year's annual dues. Second, a General Advisory Board of Past Presidents was established. Full details concerning both these items will be found in the proceedings of the meeting, published in this Journal under the second meeting of the House of Delegates. The names of the past presidents who compose the Advisory Board of Past Presidents will be found on the page indicating officers and committees, just preceding the editorials.

The scientific assemblies were well attended and the essayists made a real contribution in the presentation of fifteen well prepared scientific papers. These papers will all be published in your Journal some time during the year. The guest speaker of the Association, who was secured through President Edward Jelks, was Dr. J. M. T. Finney, Emeritus Professor of Surgery at Johns Hopkins University, Baltimore. Doctor Finney's address on "The Role of the Imponderables in Surgery" was given Wednesday forenoon. This instructive paper, interspersed with the author's inimicable humor, was a fitting climax to the scientific program.

On Monday evening Dr. Warren F. Draper, Assistant Surgeon General of the United States Public Health Service, Washington, delivered an address in the Bay Front Park, which was open to the public. Doctor Draper's address was broadcast over an NBC hookup, through the cooperation of Station WIOD and it was estimated that his audience numbered 750,000 persons.

The smoker Monday evening for doctors and their wives, was a great occasion and the committee in charge certainly did not spare their time or money. This smoker was really a free entertainment, financed by the members of the Dade County Medical Society. The Association dinner on Tuesday evening was also an unusual success. The total attendance was 430 and the program was carefully worked out by the local committee.

Entertainment of all kinds was provided by the local doctors and the Woman's Auxiliary: fishing, boating, golf, swimming, etc.

Clinics were held Monday forenoon and were well attended with keen interest by those who found it possible to arrange their affairs so as to be present.

Twelve scientific exhibits had been arranged which were a credit to any medical gathering. The first prize was won by Dr. James H. Mendel of Miami on "Ear Drums and Their Interpretation;" second prize was won by Dr. Robert B. McIver of Jacksonville on "The Surgery of the Renal Pelvis;" third prize was won by Drs. Elmo D. French and Rothwell Lefholz of Miami on "Infectious Granulomas." There were twenty-five technical exhibits which also made a definite contribution to the convention, not only from the standpoint of their displays and splendid personnel of representatives who were at their posts continually, but also by the contribution they made toward defraying the expenses in connection with the meeting. In this and last month's Journal more details have been shown concerning the convention which the readers of the Journal should find of interest.

The personnel of the Columbus Hotel gave splendid service throughout the convention and should not be overlooked when recognizing contributions toward the success of the meeting. A resolution, unanimously passed by a rising vote, put on record hearty thanks to the members of the Dade County Medical Society and their wives, the officials of the City of Miami and others who made possible such a wonderful occasion as was enjoyed in the City of Miami.

CONVENTION ECHOES

CABINET COMMITTEE

Walter C. Jones, *Chairman*

The details of committee work were made simple from the explicit directions sent out by the Managing Director of the State Medical Association. It was a pleasure to have had the opportunity of serving in the capacity of General Chairman. I feel that the success

of the Convention was due, in a great part, to the fact that the individual chairmen of the various committees functioned efficiently.

Necessarily, there were some anxious moments preceding the fulfilment of each committee's duties, but it was very gratifying upon checking at the time, to see that each chairman was carrying out his duties, and because of this, no gross errors occurred during the past meeting.

I feel that the scientific exhibits and the moving picture show were well worthwhile, and hope that this department may grow in the future, as it would be of great educational value to the Association.

I assure you that it was a great pleasure to be host to such a wonderful group of men as compose the Florida Medical Association.

COMMITTEE ON REGISTRATION

Harrison A. Walker, *Chairman*

As chairman of the Registration Committee, I am glad to report the registration at the Miami meeting broke all previous records. The total number of members and guest doctors was 534; Woman's Auxiliary, 166; and exhibitors, 62; making a grand total of 762.

The main activity of the Registration Committee was to effect the registration of the members of the Dade County Medical Society. The registration desk opened at 9 o'clock Sunday morning and an effort was made to register 100% of the local members. Each member of the Registration Committee was assigned a group of names to call by phone, urging registration on Sunday, so as to relieve congestion at the registration desk on the succeeding days when the out-of-town guests would be arriving. Of the Dade County Medical Society 212 members registered, which we are advised is the best record to date for any county society. The members of this committee enjoyed their work and are very grateful to the local doctors for their hearty response.

Badge buttons and programs were given to all who registered; also programs of the medical postgraduate short course which is to be held at Daytona Beach, June 27 to July 2. An innovation was put into effect, in the style of the badge buttons. The space for the doctor's name was shown in white and the name lettered on this space in dark green. This change in the button made it much easier to read the name.

For the convenience of those who were interested in registration, mimeographed releases, giving the names and addresses of those who registered, were given out at the registration desk each morning, beginning Monday. In conjunction with the registration desk, an information desk was established under the supervision of Doctor Hampton and Mrs. Stone. This proved to be quite a help to the doctors and guests, especially those from out of the city. In addition to a general information service, the representatives at the information desk assisted the Committee on Alumni and Fraternity Luncheons. The entire setup operated efficiently throughout the meeting.

COMMITTEE ON SCIENTIFIC EXHIBITS

James H. Mendel, *Chairman*

As chairman of the Scientific Exhibits Committee, may I take this opportunity to thank the various members of this committee and Mr. R. C. Scott, manager of the Columbus Hotel, for their help when that help was sorely needed.

Three weeks before the opening date of the convention, we had no place in which to have the scientific exhibits. Through Mr. Scott's influence, the large room off the mezzanine was obtained. The cost of erecting adequate scientific booths was high and we had very little in our budget. Dr. Adele Hampton made the contact with Mr. William Faxon of the Pacific Lumber Company, Miami, and it was Mr. Faxon's generosity, cooperation and helpful suggestions together with the fact that he and three other men from his company worked hard all day Sunday, that made possible the well constructed booths in which our members could exhibit their scientific work. Full credit must go to these two for their efforts.

To the various men who exhibited, thanks so very much for your most excellent presentations—the same thought to apply to the many societies who sent exhibits. Thanks to Dr. James Nugent for his printing of in-

numerable signs and obtaining suitable films, and to Dr. Frank Davis for seeing that they were properly shown. Mr. W. R. Lynch of the Paramount Theaters donated all the scientific signs together with the award plaques. We are most grateful to him.

The cooperation of all concerned was a delight to me. We hope the exhibits interested and instructed the members and while this is only the beginning, may this type of scientific work go on to bigger and better exhibits in the years to come.

COMMITTEE ON ASSOCIATION DINNER

M. Jay Flipse, *Chairman*

The annual Association Dinner was held on Tuesday night, May 10. Covers were laid for the 430 guests attending in the Biscayne Room of the Columbus Hotel.

Dr. Arthur Weiland, who was scheduled to act as toastmaster, was unable to attend because of the sudden death of his brother; at the last minute Dr. Ralph Greene was pressed into service as toastmaster. His remarks, always apropos, were much enjoyed by the members of the Association and their guests. It was indeed a pleasure to see Doctor Greene back in his old form after a number of years of relative retirement. Doctor Jelks and Doctor Spiers responded to toasts with short, informal talks; Dr. Tom Otto introduced Doctor Finney who appeared to enjoy telling negro stories as much as the audience enjoyed hearing them. Doctor Penn, president of the Dental Association, voiced his greetings and the greetings of his association to the Florida Medical Association.

Doctor Burbacher, nobly assisted by Doctor Milton Coplan, distributed the spoils to the golfers. There were so many prizes donated by the various business houses in Miami that it looked for a while as though all who had entered the tournament might be successful in claiming one of the awards.

Mr. Clark Fiers furnished organ music during the banquet, successfully masking the chorus of musical soup drinkers.

The banquet was followed by a dance which lasted until 2:00 a. m. Very few of the old timers could take two nights' dancing in succession so the young members had the floor to themselves. Current reports indicated that all who attended the banquet had a good time.

COMMITTEE ON SMOKER

Joseph S. Stewart, *Chairman*

In announcing the Smoker in the April Journal it was suggested that if the crowd left early as usually happens at the stag affairs then it would be a vote against including the wives in the entertainment. But if the crowd stayed until the "wee small hours" it would be a vote to include the wives for a good time.

Since there was a large crowd when the music stopped at 2:30 a. m., and since quite a number of members stayed on until 6:00 a. m., the Committee must conclude that a good time was had by all. We must conclude also that the doctors in Florida enjoy their entertainment with their wives.

The Smoker Committee hopes that the conclusions are correct. Some of our friends have been good enough to tell us that they think the conclusions are correct; however, the only way we have to find out for sure is to see what future conventions bring forth.

ANGLERS' COMMITTEE

Thomas O. Otto, *Chairman*

Dr. J. M. T. Finney of Baltimore, distinguished guest and honored speaker, proved his prowess in the piscatorial art by boating a seven-foot, six-inch sailfish on Thursday, May 12, during his first trip to Miami and the gulf stream. This beautiful specimen is being mounted and forwarded to Doctor Finney as a trophy of his visit to the Florida convention.

Dr. Edward Jelks, immediate past president, likewise shared honors by landing his first sailfish on the same trip with Doctor Finney.

Another party, including Drs. L. Y. Dyrenforth, Ferdinand Richards and E. C. Swift, made a trip through Biscayne Bay to the edge of the gulf stream and Doctor Dyrenforth was successful in landing a fifty-pound sailfish and a twenty-pound king mackerel.

The Anglers' Committee was somewhat disappointed in that comparatively few of the large number who attended showed an interest in fishing, but apologizes for any irregularity of schedule encountered by those

desiring to fish. This was occasioned by the failure of those interested in fishing to make reservations for boats prior to the opening of the convention, as requested in the Journal.

We Dade County doctors look forward to another convention in Miami and assure you all of a great welcome whenever it will be our good fortune to play host again to such a representative group of doctors.

COMMITTEE ON GOLF

Charles R. Burbacher, *Chairman*

Ninety-four golfers and would-be golfers competed for two trophies and merchandise valued at $200.00 on May 9 and 10 at the Miami-Biltmore Country Club.

Dr. J. Sayad of Palm Beach won the rotating Orlando Handicap Trophy. The low gross trophy, compliments of Greenleaf & Crosby Company, went to Dr. Wm. H. McCullagh of Jacksonville. The runners-up were Dr. C. A. Rudisill of Tampa and Dr. Frank S. Adamo of Tampa. Additional prizes were presented to the runners-up in the handicap division, as well as to the golfer turning in the highest score and the player making the most 7's. A quart of Ronrico was the reward for each birdie made during the tournament. Two quarts were given to each of the ten low scores, excepting those who received other prizes. This liquid merchandise was with the compliments of the McKesson-Groover-Stewart Drug Company and the Ronrico Corporation.

Sixty-five golfers competed in the Blind Bogey Tournament with an entrance fee of $1.00. The lucky net score was 82 with seven names tied for the prize. The drawing was in favor of Dr. Shaler Richardson who received a set of matched wood clubs. The other six of the group received more Ronrico.

Presentation of the prizes was a part of the banquet program and we trust that additional interest in our annual tournament was created at that time. All contestants were guests of the Miami-Biltmore Country Club, to whom we owe a debt of appreciation for this kind gesture.

The following were donors of our prize list:

Surgical Selling Company.

Surgical Supply Company.

Dade Pharmacies.

Greenleaf and Crosby Company.

McKesson-Groover-Stewart Drug Company.

American Optical Company.

Southeastern Optical Company.

Ronrico Corporation, Fred Meyer, Distr.

Burdine's.

Fossett's Pharmacy.

Ned Everhard, professional at the Miami-Biltmore Country Club, handled the entries and handicapping.

COMMITTEE ON PARK PROGRAM AND RADIO BROADCAST

Warren W. Quillian, *Acting Chairman*

As a footnote to the general theme of the recent State Convention in Miami, the program in Bay Front Park, was produced as an educational feature for laymen. The weather man was considerate. Balmy weather encouraged the faithful few of the medical group, as well as several hundred interested local citizens, to venture forth to the outdoor amphitheatre where the meeting was held on Monday evening, May 9. A preliminary musical program was presented by the University of Miami band under the able leadership of Mr. Walter Schaeffer.

The featured attraction of the evening was an address by Dr. Warren F. Draper, Assistant Surgeon General of the United States Public Health Service. His subject, "A Healthier Life and a Happy One," referred to public responsibility in the solution of health problems. Doctor Draper's tremendous experience, covering twenty-seven years of continuous activity in organized health work, gave him the well deserved attention of his audience. His remarks were forceful and indicated that the speaker had the courage of his convictions.

With the cooperation of WIOD, Doctor Draper's address was broadcast over the NBC hook-up. Local officials informed the committee that the potential audience listening in would be approximately 750,000 persons. This fact greatly multiplied the effectiveness of the program from the standpoint of public education. Many comments reflect the favorable reaction with which the address was received by the public. The Committee feels that the state organization was fortunate in obtaining

for this program a man whose qualifications designate him as a leader of medical and public health progress in the United States.

COMMITTEE ON ALUMNI AND FRATERNITY LUNCHEONS

James J. Nugent, *Chairman*

During the recent convention, alumni of thirty-one medical schools assembled for luncheon in the Alcazar Hotel. At the same time fifty members of the Phi Beta Pi Fraternity were renewing acquaintances at the University Club. The attendance was perhaps larger than at any previous convention.

Many new associations were made and in several cases, old acquaintances were surprised to learn that they were alumni of the same school. It was only natural that conversations ran "way back when" as each alumnus re-established his associations with his earliest days of medicine. Recollections were flavored with joy and sadness as the curtain of time was thrown back. The innate desire for a family reunion was satisfied.

COMMITTEE ON TRANSPORTATION

W. Duncan Owens, *Chairman*

The Miami Police Department cooperated with us in every way, so as to provide ample parking facilities in the neighborhood of the Columbus Hotel, our headquarters. They were also good enough to issue instructions to all officers that they were to see to it that we had a good time. This cooperation was obtained by a simple interview at Police Headquarters.

The only other job assigned to us was seeing that transportation was available to and from the Coral Gables Country Club on Monday night. This was obtained with some difficulty because of conflicting ordinances in the cities of Miami and Coral Gables, but was satisfactorily arranged by obtaining one taxi company to go out to Coral Gables and another taxi company to come back from Coral Gables.

I may say that the Woman's Auxiliary made its own arrangements and thereby relieved my committee of what could have been an arduous task.

Ours was a new committee and for that reason we had absolutely no idea of what our duties might be when we started out.

COMMITTEE ON CLINICS

J. W. Snyder, *Chairman*

We wish to thank the men who were so kind as to devote their time and effort to make the clinic morning a success. While the idea was a new one the members of the Association attended the various clinics very well and many showed keen interest in what was going on. We believe that this sort of program might with advantage be adopted by the Association, and the local men each year should be encouraged to present various subjects. Our Committee feels that in spite of the distance of the hospitals from headquarters the attendance and the interest shown by the visiting men very well compensated for the effort made in arranging such a clinical morning.

MEDICAL DISTRICT MEETINGS

Panama City (A) . . . . . July 14, 1938
Ponte Vedra (C) . . . . . September 15, 1938
Bradenton (D) . . . . . September 29, 1938
Ft. Lauderdale (F) . . . . . October 13, 1938
Gainesville (B) . . . . . October 27, 1938
Leesburg (E) . . . . . November 10, 1938

STATE NEWS ITEMS

Dr. Hilliard W. Willis of Coral Gables announces the removal of his offices to 2605 Ponce de Leon Avenue, where he will specialize in diseases of infancy and childhood.

* * *

Dr. and Mrs. S. H. Adams of Bartow, announce the birth of a son, Samuel Henderson, Jr., on April 17, 1938, at Tampa Municipal Hospital.

* * *

Dr. and Mrs. J. Lloyd Massey of Quincy, announce the birth of a son, James Lloyd, Jr., on May 12, 1938, at the Gadsden County Hospital. He is the grandson of Dr. and Mrs. W. W. Massey of Quincy.

* * *

Dr. William G. Doern of Daytona Beach will do research work in cancer and leukemia during the summer months, at Mercy Hospital, Milwaukee, Wis.

Dr. Herbert L. Bryans has returned from New York City where he attended a post-graduate course and also the annual meeting of the American College of Physicians.

* * *

At a meeting of the State Board of Medical Examiners held in Jacksonville June 13 and 14, in connection with the semi-annual examination, Dr. Julius C. Davis of Quincy was re-elected president. Other officers elected were: Dr. Harold D. Van Schaick of Jacksonville, vice president; Dr. William M. Rowlett of Tampa, secretary-treasurer.

* * *

The memory of Dr. Calvin D. Christ was revered in a beautiful and appropriate memorial program at the Phi Beta Pi annual luncheon during the recent convention in Miami. The luncheon was well attended and each man spoke highly of the late Doctor Christ.

* * *

Dr. Gerry R. Holden, Jacksonville and Dr. Homer L. Pearson, Miami, were the official delegates from Florida to the annual meeting of the Medical Association of Georgia, held at Augusta, April 26-29. In addition to the official delegates, the following members of the Florida Medical Association attended the Georgia meeting:

Boynton, Charles E., West Palm Beach.
Carter, Claude L., Inverness.
Davis, T. Hartley, Shamrock
Fort, F. L., Jacksonville
Hall, Young L., Jr., Miami
Harris, William G., Jacksonville
Howell, R. Spencer, Miami
Jelks, Edward, Jacksonville
Massey, W. W., Quincy
Mathews, A. L., Sarasota
Oetjen, G. F., Jacksonville
Richardson, George W., Jacksonville
Stewart, J. S., Miami
Taylor, T. W., Sarasota
Waas, F. J., Jacksonville.

* * *

The Orange County Medical Society will hold its annual picnic and barbecue possibly the latter part of August. A complete announcement will be made in next month's Journal.

* * *

Dr. E. Frank McCall, formerly of Hobe Sound, has opened offices at Florida Avenue and First Street, Neptune Beach.

* * *

Dr. and Mrs. M. A. Lischkoff of Pensacola attended the commencement exercises at Gulf Park College where their daughter, Blanche, was among those who graduated.

The regular quarterly meeting of the Florida Society of Dermatology and Syphilology was held at the Dade County Court House, Miami, on May 8, 1938, at 9 a m. After an interesting clinic and discussion of cases, the meeting was adjourned by Dr. Elmo D. French, chairman, and was followed by a luncheon and business meeting, at which time it was decided to hold the next quarterly meeting of the society at Jacksonville in the fall. The election of officers will be held at the Jacksonville meeting.

Members present were:

C. A. Andrews of Tampa, president;
Elmo D. French of Miami, chairman;
Lauren McC. Sompayrac of Jacksonville, secretary;
G. C. Bottari, Tampa
Alan Brown, Jacksonville
J. Lee Kirby-Smith, Jacksonville
A. B. Litterer, Miami
G. N. MacDonell, Miami
L. B. Mount, St. Petersburg
S. F. Ricker, Orlando
W. M. Sams, Miami
J. Frank Wilson, Jacksonville

Guests of the Society were Drs. Rothwell Lefholz and Paul Mapother of Miami.

* * *

At the Seventh Annual Meeting of the Florida Radiological Society, held in Miami, May 9, 1938 at the Columbus Hotel, the following officers were elected: President, Dr. H. O. Brown of Tampa; Vice-President, Dr. H. B. McEuen of Jacksonville; and Secretary, Dr. Joseph H. Lucinian of Miami.

* * *

Dr. and Mrs. I. A. Dailey of Micanopy announce the birth of a daughter, Marcia Ann, on March 15, 1938.

* * *

Dr. W. B. Moon of Crystal River was recently chosen chairman of the Fifth Congressional District Democratic Executive Committee, at a meeting aboard a boat, during a fishing trip on which Doctor Moon entertained the members.

* * *

Dr. A. L. Stebbins, since leaving Punta Gorda last September, has taken a course in public health at Chapel Hill, N. C. He is now director of the Escambia County Health Unit at Pensacola.

* * *

Dr. Allen P. Gurganious of Palatka visited in Canada on his return trip from the A.M.A. meeting in San Francisco.

Dr. Edward Jelks of Jacksonville was the guest speaker at the Georgia Medical Society at the meeting held in Savannah, Tuesday, May 24. Doctor Jelks' paper was entitled "Heart Action as an Indicator of Irregularities of the Thyroid."

The Chatham County Medical Society was organized prior to the State Association and was originally known as the Georgia Medical Society. Later, the State Association was organized under the name of the Medical Association of Georgia.

* * *

Dr. A. J. Logie of Jacksonville acted as host to Dr. Bela Schick of New York City, the originator of the Schick Test, who spoke on tuberculosis in childhood before a number of county medical societies in South Florida during the month of May. Doctor Logie is director of the Division of Tuberculosis of the State Board of Health.

* * *

Dr. and Mrs. Victor A. Hughes and small son of Jacksonville have returned from a visit in South Pittsburg, Tenn.

* * *

Dr. J. C. Pate of Tampa gave the graduating address to the 1938 class of nurses of the Tampa Municipal Hospital on May 12. His subject was "The Art of Living."

PERRY M. LEWIS

Dr. Perry M. Lewis of Orlando died at his home on April 30, at the age of 46. He had been in ill health and had led a life of almost constant inactivity for the past six years.

Born near Bainbridge, Georgia in 1892, Doctor Lewis secured his medical training at Emory University, from which he graduated in 1915. He took the State Board examination in Florida in 1923 after which he located at Orlando, limiting his practice to diseases of the eye, ear, nose and throat. He was a member of the Orange County Medical Society, honorary member of the Florida Medical Association, and a member of the American Medical Association.

Doctor Lewis is survived by his widow, Cora, and one daughter, Mrs. Julian J. Smoak, Jr. of Lakeland.

JOHN CLARENCE KNIGHT

Dr. John C. Knight of Plant City died suddenly at his home on March 6. Death was due to coronary thrombosis.

Doctor Knight was born in this section of Florida sixty-six years ago and here received his preliminary education. He attended the Medical Department of the University of Nashville from which he graduated in 1900. He then returned to Plant City to begin his practice and remained for the balance of his life.

By virtue of his splendid character and warm friendship, Doctor Knight was widely known and loved, not only in his own home town and vicinity, but throughout this section of the State. He was a Mason and a Shriner, a member of the Elks lodge, the Plant City Kiwanis club and the First Baptist Church. He was city health physician at the time of his death, which office he had held for a number of years.

Besides his wife, Mrs. Mary Wells Knight, he is survived by a son, John C. Knight of Bartow; a daughter, Mrs. O. O. Ashworth of Richmond; his parents, Mr. and Mrs. W. S. Knight of Plant City; four brothers and three sisters.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

At the meeting of the Dade County Medical Society held June 7 at 8:30 p. m., in the Ingraham Building, the following papers constituted the scientific program: "Hypoglycemic Shock Therapy" (films illustrating the method)—James L. Anderson, Miami. "Diagnosis of Pregnancy"—Ralph Jack, Miami. Doctors E. F. Fox and Buist Litterer opened the discussion.

DUVAL COUNTY MEDICAL SOCIETY

At a meeting of the Duval County Medical Society held June 4 at the Florida Yacht Club, the program consisted of a symposium on Peptic Ulcer, presented as follows:

"From the Viewpoint of the Radiologist," Frederick K. Herpel, West Palm Beach.

"From the Viewpoint of the Internist," Herbert L. Bryans, Pensacola.

"From the Viewpoint of the Surgeon," J. S. Turberville, Century.

LAKE COUNTY MEDICAL SOCIETY

THE LAKE COUNTY MEDICAL SOCIETY STANDS 100% PAID FOR 1938. THIS SOCIETY WHICH HAS SIXTEEN MEMBERS IS HEADED BY DR. H. T. FENN OF MOUNT DORA, PRESIDENT; DR. W. G. DEVANE, GROVELAND, VICE PRESIDENT; AND DR. W. L. ASHTON OF UMATILLA, SECRETARY-TREASURER. CONGRATULATIONS, LAKE COUNTY MEDICAL SOCIETY.

* * *

MANATEE COUNTY MEDICAL SOCIETY

THE MANATEE COUNTY MEDICAL SOCIETY HAS JOINED THE HONOR ROLL OF 100% PAID SOCIETIES. DR. JOHN F. MASON OF BRADENTON IS PRESIDENT OF THE SOCIETY; DR. W. E. WENTZEL OF BRADENTON, VICE-PRESIDENT; AND DR. M. M. HARRISON, BRADENTON, SECRETARY-TREASURER. THIS SOCIETY IS COMPOSED OF TWELVE ACTIVE MEMBERS AND ONE LIFE MEMBER.

* * *

PINELLAS COUNTY MEDICAL SOCIETY

At the meeting of the Pinellas County Medical Society held at the Chatterbox on the evening of May 19, Dr. Bela Schick of New York was guest speaker. His subject was "Schick Test and Tuberculosis in Childhood." Graduate and student nurses were invited to attend this meeting.

At the meeting of the Society held June 3, the program consisted of a symposium on "Tuberculosis." This was presented as follows:

"Tuberculin Tests (lantern slides)" — A. J. Logie, Jacksonville.

"Diagnosis (X-ray plates)" — R. D. Thompson, Orlando.

"Treatment"—A. S. Anderson, St. Petersburg.

"Public Health Problem"—W. H. Pickett, St. Petersburg.

The Presidents of the P.-T. A. were guests at this meeting.

ABSTRACT DEPARTMENT

Members of the Florida Medical Association who have had articles published in out-of-state medical journals are requested to forward such journals or reprints to Box 1018, Jacksonville, for abstracting in this department.

The Rectum as a Focus of Infection—Alexander, O. R., Winter Haven, *Medical World*, **55**:269 (Apr.), 1937.

Because of the emphasis of modern medicine on foci of infection as the cause of many diseases and innumerable symptoms, the author wishes to call attention to the rectum and anus as a site for such focus or as a region where irritations such as fissures or hemorroids may originate reflex pains. Cryptitis and papillitis in the rectum set up the ideal conditions for chronic foci and may lead to fissure in ano. Cryptitis also frequently leads to ischiorectal abscess and chronic pruritus. Two short case reports are appended.

Congenital Duodenal Atresia—Rose, Joseph, Washington, D. C. (now Hastings, Fla.), and Jay, Angelo, M., Jr., Washington, D. C., *J. Ped.* **10**:490 (April), 1937.

The etiology of congenital duodenal atresia may be intrinsic, due to the failure of the lumen of the gut to reopen at the end of the twelfth week, or extrinsic and result from arrest in rotation of the viscera, malformation of the superior mesenteric vessels, congenital adenoma, peritoneal bands or annular pancreas.

The diagnosis is based on the history of vomiting from birth, x-ray examination and examination of the stools. With duodenal atresia there is an absence of keratinized cells and lanugo hairs, ordinarily found in the early stools of the new-born. Pyloric stenosis is the condition with which it is most often confused.

Treatment is obviously surgical. Gastroenterostomy or side to side duodenojejunostomy are the methods of choice.

The authors report two cases, in both of which, it is interesting to note, the patients had patent ductus arteriosus and foramen ovale.

Factors Influencing the Muscular Activity of the Normal Colon—Welch, P. B., Miami. Am. J. Digestive Diseases & Nutrition 4:382-386 (Aug.) 1937.

Welch reviews the available literature pertaining to extrinsic and intrinsic factors influencing the muscular activity of the colon and adds the results of several of his own experiments.

Among the varying extrinsic factors he cites taking of food (a definite appetite or taste reflex, similar to Pavlov's appetite reflex in the production of gastric secretion), endocrine, metabolic and allergic disturbances, stimuli originating in adjacent viscera, bodily and mental activity and sleep.

The author was able to arrive at several interesting conclusions regarding intrinsic factors involved in colon activity, through the use of condom balloons inserted into the proximal and distal openings of 5 colostomized negro women. These balloons were inflated with water and definite though varying hydrostatic pressures were utilized. Kymographic tracings were obtained showing the actual extent of muscle contraction.

With water pressure of 1 inch or less the colonic contractions were of little tone, infrequent, irregular and of short duration. Increase of pressure invariably increased the frequency and tone of the contractions.

With prolonged distention this irritability gradually lessened, the tone slowly lowered and the contractions were of shorter duration, until within 2 hours the tracings resembled that of a resting colon.

The author compares the latter finding to that observed in the rectum when the stimulation to evacuation is disregarded with gradual depression or loss of the defecation reflex. This inhibition of activity is likely due to loss of irritability of the neuromuscular apparatus.

The important result of the authors' experiments lies in the conclusion that the amount and character of the residue in the lumen of the colon are potent factors in the determination of its muscular activity.

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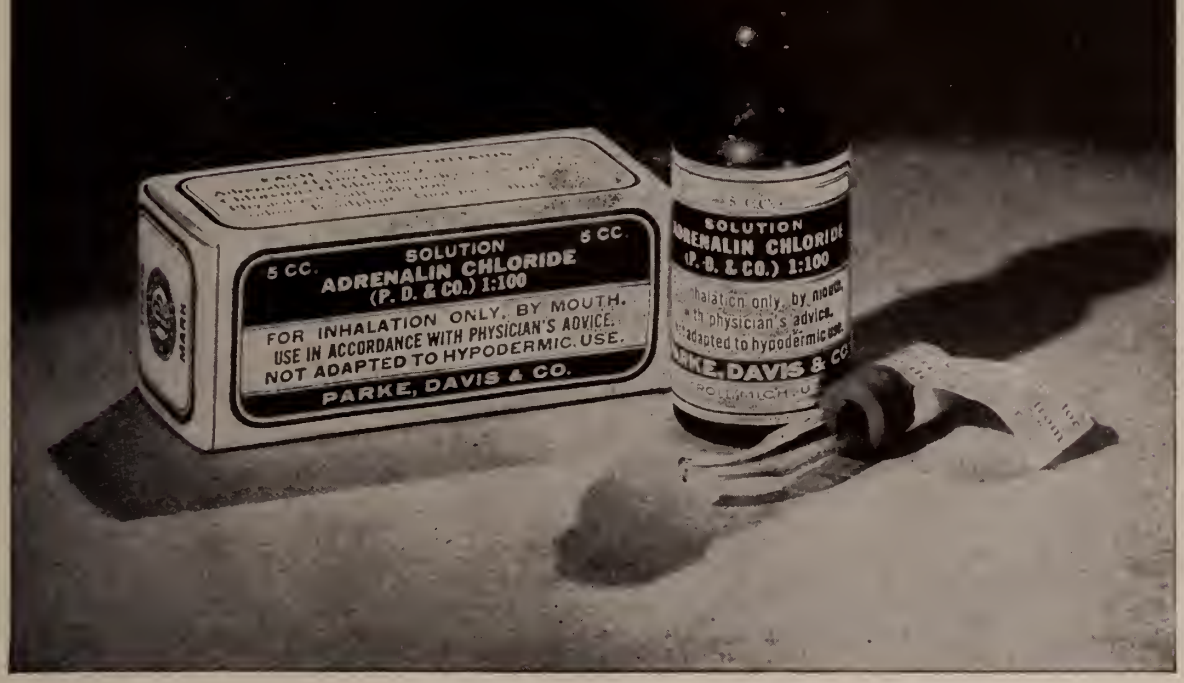
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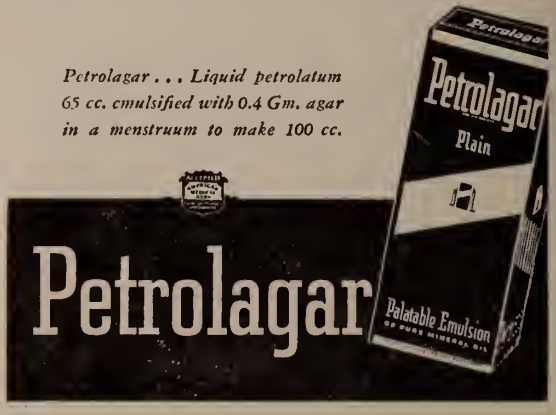


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Districts	COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	COUNCILOR *and Counties Not Included in First Column*	Members	
						Total	Paid
Northwest District (A) Panama City July 14, 1938	Bay	W. J. Blackshear, M.D., Panama City	William C. Roberts, M. D., Panama City		A-1-'40 Carol C. Webb, M. D., Pensacola	11	9
	Escambia	J. M. Hoffman, M. D., 1221 E. DeSoto St., Pensacola	J. N. McLane, M. D., 204 W. Brainard St., Pensacola	2nd Tuesday 8:00 P. M.		41	36
	Walton-Okaloosa	A. G. Williams, M. D., Lakewood	R. B. Spires, M. D., DeFuniak Springs	3rd Thursday 8:00 P. M.		6	100%
	Washington-Holmes	B. W. Dalton, M. D., Vernon	R. H. Segrest, M. D., Bonifay		*Santa Rosa*	8	100%
	Jackson	D. A. McKinnon, M. D., Marianna	R. N. Joyner, M. D., Marianna	2nd Tuesday 7:30 P. M.	A-2-'39 N. A. Baltzell, M. D., Marianna	16	13
	Leon-Gadsden-Liberty-Wakulla-Jefferson	W. D. Rogers, M. D., Chattahoochee	B. A. Wilkinson,, M. D., Telephone Bldg., Tallahassee	Quarterly 3:00 P. M.	*Calhoun-Franklin-Gulf*	38	33
North Central District (B) Gainesville, October 27, 1938	Columbia	William S. Nichols, M. D., Lake City	Harry S. Howell, M. D., Blanch Hotel Annex, Lake City	1st Monday 7:30 P. M.	B-3-'39 R. B. Harkness, M. D., Lake City	18	15
	Madison	E. Long, M. D., Madison	Geo. O. Davis, M. D., Madison			4	3
	Taylor	Ralph J. Greene, M.D., Perry	W. J. Baker, M. D., Foley	Last Friday 8:00 P. M.	*Baker-Dixie-Hamilton-Lafayette-Suwannee*	8	6
	Alachua	T. A. Snow, M. D., 103 E. University Ave., Gainesville	H. M. Merchant, M. D., 124 E. University Ave., Gainesville	2nd Friday 7:30 P. M.	B-4-'40 James L. Strange, M. D., McIntosh	27	21
	Marion	Carney W. Mimms, M. D., Commercial Bank Bldg. Ocala	R. C. Cumming, M. D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P. M.		22	21
	Pasco-Hernando-Citrus	Samuel C. Harvard, M. D., Brooksville	G. R. Creekmore, M. D., Brooksville	2nd Thursday 7:00 P. M.		14	12
	Sumter	Clyde L. Carter, M.D., Wildwood	W. E. Mitchell, M. D., Bushnell	2nd Tuesday	*Bradford-Gilchrist-Levy-Union*	5	100%
N. E. District (C) Ponte Vedra Sept. 15, 1938	Duval	J. Lunsford Boone, M. D., 500 Professional Bldg., Jacksonville	Georga W. Croft, M. D., 713 Greenleaf Bldg., Jacksonville	1st Tuesday 8:15 P. M.	C-5-'39 W. McL. Shaw, M. D., Jacksonville	161	140
	St. Johns	John J. Spencer, M.D., 32 Saragossa St., St. Augustine	Vernon A. Lockwood, M.D., East Coast Hospital St. Augustine	3rd Tuesday 8:30 P. M.	*Clay-Nassau*	10	100%
	Putnam	Z. Brantley, M.D., Grandin	Allen P. Gurganious, M.D., Palatka	2nd Tuesday in Feb., April, June, Aug., Oct., Dec. 7:00 P. M.	C-6-'40 George M. Green, M. D., Daytona Beach	10	9
	Volusia	Hugh West, M. D., DeLand	R. L. Miller, M. D., 258½ S. Beach St., Daytona Beach	2nd Tuesday 7:30 P. M.	*Flagler*	39	34
Southwest District (D) Bradenton, September 29, 1938	Hillsborough	Joseph W. Taylor, M. D., 706 Franklin St., Tampa	James S. Grable, M. D., 811 Citizens Bank Bldg., Tampa	1st Tuesday 8:00 P. M.	D-7-'39 J. W. Alsobrook, M. D., Plant City	108	93
	Manatee	John F. Mason, M. D., Bradenton	M. M. Harrison, M. D., Bradenton	3rd Tuesday 7:00 P. M.		13	100%
	Pinellas	J. A. Strickland, M. D., 712 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D., 1005 Equitable Bldg., St. Petersburg	1st and 3rd Fridays 6:30 P. M.		90	89
	Sarasota	O. H. Cribbins, M. D., 224 Commercial Court, Sarasota	J. E. Harris, M. D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P. M.		15	12
	DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring	Howard V. Weems, M.D., Sebring	2nd Tuesday 8:00 P. M.	D-8-'40 Herman Watson, M. D., Lakeland	18	16
	Lee	H. Quillian Jones, M. D., 18-20 Leon Bldg., Fort Myers	Harrie J. Stipe, M. D., 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P. M.		13	11
	Polk	W. W. Shafer, M. D., Haines City	J. R. Boulware, Jr., M. D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P. M.	*Charlotte-Collier-Glades-Hendry*	63	52
South Central District (E) Leesburg, Nov. 10, 1938	Brevard	G. E. Christie, M.D., Titusville	L. K. Hicks, M.D., Melbourne	3rd Tuesday	E-9-'40 W. C. Page, M D., Cocoa	12	100%
	Lake	Harry T. Fenn, M. D., Mount Dora	W. L. Ashton, M. D., Umatilla	1st Thursday 12:30 P. M.		16	100%
	Orange	H. A. Day, M.D., 209 Exchange Bldg., Orlando	Hewitt Johnston, M. D., Box 2002 Orlando	3rd Wednesday 8:30 P. M.		72	100%
	Seminole	J. N. Tolar, M. D., Sanford	Douglas G. Scott, M. D., Box 489 Sanford	2nd Monday 7:00 P. M.	*Osceola*	13	100%
	St. Lucie-Okeechobee-Indian River-Martin	R. C. Boothe, M.D., Ft. Pierce	Adrian M. Sample, M.D., Ft. Pierce	3rd Thursday 8:00 P. M.	E-10-'39 H. D. Clark, M. D., Ft. Pierce	15	100%
S. E. District (F) Ft. Lauderdale Oct. 13, 1938	Broward	A. E. Connor, M. D., Sweet Bldg., Ft. Lauderdale	Oliver C. Brown, M. D., 915 Sweet Bldg., Fort Lauderdale	4th Wednesday 8:00 P. M.	F-11-'40 Lloyd J. Netto, M. D., West Palm Beach	31	100%
	Palm Beach	V. M. Johnson, M.D., Good Samaritan Hospital, W. Palm Beach	J. R. Sory, M.D., 616 Harvey Bldg., West Palm Beach	4th Monday 8:00 P. M.		57	55
	Dade	Arthur H. Weiland, M. D., 227 Aragon Ave., Coral Gables	Claude G. Mentzer, M. D., 808 Huntington Bldg., Miami	1st Tuesday 8:30 P. M.	F-12-'39 H. A. Walker, M. D., Miami Beach	281	2[illegible]
	Monroe	Harry C. Galey, M. D., 532 Fleming St., Key West	W. R. Warren, M. D., 511 Eaton St., Key West	1st Sunday 9:00 P. M.		3	



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